

CHAPTER 355

HEALTH CARE POLICY AND FINANCING

SENATE BILL 06-219

BY SENATOR(S) Keller, and Boyd;
also REPRESENTATIVE(S) Jahn, Larson, McGihon, and Stafford.

AN ACT

CONCERNING AN ADMINISTRATIVE REORGANIZATION OF PROGRAMS ADMINISTERED BY THE STATE
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, AND MAKING AN APPROPRIATION
THEREFOR.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Part 1 of article 1 of title 25.5, Colorado Revised Statutes, is amended to read:

PART 1
GENERAL PROVISIONS

25.5-1-101. Short title. This title shall be known and may be cited as the "State Health Care Policy and Financing Act".

25.5-1-102. Legislative declaration. (1) The general assembly declares that state and local policymakers and health and human services administrators recognize that the management of and the delivery system for health and human services have become complex, fragmented, and costly and that the health and human services delivery system in this state should be restructured to adequately address the needs of Colorado citizens.

(2) The general assembly further finds and declares that a continuing budget crisis makes it unlikely that funding sources will keep pace with the increasing demands of health and human services.

(3) Therefore, the general assembly finds that it is appropriate to restructure principal departments responsible for overseeing the delivery of health and human services and to reform the state's health and human services administration and

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

delivery system, using guiding principles and within the time frames set forth in article 1.7 of title 24, C.R.S., AS SAID ARTICLE EXISTED PRIOR TO JULY 1, 1997. It is the general assembly's intent that the departments of public health and environment, health care policy and financing, and human services be operational, effective July 1, 1994.

25.5-1-103. Definitions. As used in this title, unless the context otherwise requires:

~~(1) Repealed.~~

(1) "COUNTY BOARD" MEANS THE COUNTY OR DISTRICT BOARD OF SOCIAL SERVICES; EXCEPT THAT, IN THE CITY AND COUNTY OF DENVER, "COUNTY BOARD" MEANS THE DEPARTMENT OR AGENCY WITH THE RESPONSIBILITY FOR PUBLIC ASSISTANCE AND WELFARE ACTIVITIES, AND, IN THE CITY AND COUNTY OF BROOMFIELD, "COUNTY BOARD" MEANS THE CITY COUNCIL OR A BOARD OR COMMISSION WITH THE RESPONSIBILITY FOR PUBLIC ASSISTANCE AND WELFARE ACTIVITIES APPOINTED BY THE CITY AND COUNTY OF BROOMFIELD.

(2) "COUNTY DEPARTMENT" MEANS THE COUNTY OR DISTRICT DEPARTMENT OF SOCIAL SERVICES.

(3) "COUNTY DIRECTOR" MEANS THE DIRECTOR OF THE COUNTY OR DISTRICT DEPARTMENT OF SOCIAL SERVICES.

~~(2)~~ (4) "Executive director" means the executive director of the department of health care policy and financing.

(5) "MEDICAL ASSISTANCE" MEANS ANY PROGRAM ADMINISTERED BY THE STATE DEPARTMENT, INCLUDING BUT NOT LIMITED TO THE "COLORADO MEDICAL ASSISTANCE ACT", AS SPECIFIED IN ARTICLES 4, 5, AND 6 OF THIS TITLE, THE "CHILDREN'S BASIC HEALTH PLAN ACT", ARTICLE 8 OF THIS TITLE, THE OLD AGE PENSION HEALTH AND MEDICAL CARE PROGRAM, AND THE SUPPLEMENTAL OLD AGE PENSION HEALTH AND MEDICAL CARE PROGRAM; EXCEPT THAT "MEDICAL ASSISTANCE" FOR PURPOSES OF ARTICLES 4, 5, AND 6 OF THIS TITLE SHALL HAVE THE MEANING AS DEFINED IN SECTION 25.5-4-103 (13).

(6) "RECIPIENT" MEANS ANY PERSON WHO HAS BEEN DETERMINED ELIGIBLE TO RECEIVE BENEFITS OR SERVICES UNDER THIS TITLE.

~~(2.5)~~ (7) "State board" or "board" means the medical services board created pursuant to section 25.5-1-301.

~~(3)~~ (8) "State department" means the department of health care policy and financing.

~~(4)~~ (9) "STATE DESIGNATED AGENCY" MEANS AN AGENCY DESIGNATED TO PERFORM SPECIFIED FUNCTIONS THAT WOULD OTHERWISE BE PERFORMED BY THE COUNTY DEPARTMENTS, INCLUDING THE SINGLE ENTRY POINT AGENCIES AND MEDICAL ASSISTANCE SITES.

25.5-1-104. Department of health care policy and financing created - executive director - powers, duties, and functions. (1) There is hereby created the department of health care policy and financing, the head of which shall be the executive director of the department of health care policy and financing, which office is hereby created. The executive director shall be appointed by the governor, with the consent of the senate, and shall serve at the pleasure of the governor. The reappointment of an executive director after an initial election of a governor shall be subject to the provisions of section 24-20-109, C.R.S. The executive director has those powers, duties, and functions prescribed for the heads of principal departments in the "Administrative Organization Act of 1968", article 1 of title 24, C.R.S., and any powers, duties, and functions set forth in this title.

(2) The department of health care policy and financing shall consist of an executive director of the department of health care policy and financing, the medical services board, and such divisions, sections, and other units as shall be established by the executive director pursuant to the provisions of subsection (3) of this section.

(3) The executive director may establish such divisions, sections, and other units within the state department as are necessary for the proper and efficient discharge of the powers, duties, and functions of the state department; except that such action by the executive director shall not conflict with the implementation requirements for the plan for restructuring the delivery of health and human services in this state, as set forth in article 1.7 of title 24, C.R.S.

(4) The department of health care policy and financing shall be responsible for the administration of the functions and programs as set forth in ~~part 2 of this article~~ THIS TITLE.

25.5-1-105. Transfer of functions - employees - property - records. (1) The state department shall, on and after July 1, 1994, execute, administer, perform, and enforce the rights, powers, duties, functions, and obligations vested prior to July 1, 1994, in the Colorado health data commission within the department of local affairs, the department of social services concerning the "Colorado Medical Assistance Act", ~~adult foster care, home care allowance, and the treatment program for high-risk pregnant women;~~ and the university of Colorado health sciences center concerning health care for the medically indigent.

(2)(a) ~~On and after July 1, 1994, all positions of employment in the department of local affairs, the department of social services, the health sciences center, and the department of regulatory agencies concerning the powers, duties, and functions transferred to the department of health care policy and financing pursuant to this article and determined to be necessary to carry out the purposes of this article by the executive director of the department of health care policy and financing shall be transferred to the department of health care policy and financing and shall become employment positions therein. The executive director shall appoint such employees as are necessary to carry out the duties and exercise the powers conferred by law upon the state department and the executive director. On and after July 1, 1994, any appointment of employees and any creation or elimination of positions of employment shall be consistent with the plan for restructuring health and human services as set forth in article 1.7 of title 24, C.R.S. Appointing authority may be delegated by the executive director as appropriate.~~

~~(b) On and after July 1, 1994, all employees of the department of local affairs, the department of social services, the health sciences center, and the department of regulatory agencies whose duties and functions concerned the powers, duties, and functions transferred to the department of health care policy and financing pursuant to this article, regardless of whether the position of employment in which the employee served was transferred, shall be considered employees of the department of health care policy and financing for purposes of section 24-50-124, C.R.S. Such employees shall retain all rights under the state personnel system and to retirement benefits pursuant to the laws of this state, and their services shall be deemed continuous.~~

~~(3) On July 1, 1994, all items of property, real and personal, including office furniture and fixtures, books, documents, and records of the department of local affairs, the department of social services, and the department of regulatory agencies pertaining to the duties and functions transferred to the department of health care policy and financing are transferred to the department of health care policy and financing and shall become the property thereof.~~

~~(4) On and after July 1, 1994, whenever the department of local affairs, the department of social services, the department of regulatory agencies, or the university of Colorado health sciences center is referred to or designated by any contract or other document in connection with the duties and functions transferred to the department of health care policy and financing, such reference or designation shall be deemed to apply to the department of health care policy and financing. All contracts entered into by the said departments prior to July 1, 1994, in connection with the duties and functions transferred to the department of health care policy and financing are hereby validated, with the department of health care policy and financing succeeding to all rights and obligations under such contracts. Any cash funds, custodial funds, trusts, grants, and any appropriations of funds from prior fiscal years open to satisfy obligations incurred under such contracts shall be transferred and appropriated to the department of health care policy and financing for the payment of such obligations.~~

~~(5) On and after July 1, 1994, unless otherwise specified, whenever any provision of law refers to the department of local affairs with respect to the Colorado health data commission; to the state department or state department of social services in connection with the "Colorado Medical Assistance Act", adult foster care, home care allowance, or the treatment program for high-risk pregnant women; to the department of regulatory agencies concerning "The Colorado Care Health Insurance Program"; or to the university of Colorado health sciences center in connection with health care for the medically indigent; said law shall be construed as referring to the department of health care policy and financing.~~

~~(6)~~ (2) All rules, regulations, and orders of the department of local affairs, the state department of social services, the state board of social services, the department of regulatory agencies, and the university of Colorado health sciences center adopted prior to July 1, 1994, in connection with the powers, duties, and functions transferred to the STATE department ~~of health care policy and financing~~ shall continue to be effective until revised, amended, repealed, or nullified pursuant to law. On and after July 1, 1994, the ~~medical services~~ STATE board or the executive director, whichever is appropriate, shall adopt rules necessary for the administration

of the state department and the administration of the programs set forth in ~~part 2 of this article~~ THIS TITLE. ~~Any rules adopted by the medical services board or the executive director, whichever is appropriate, on and after July 1, 1994, shall be consistent with the plan for restructuring the health and human services delivery system, as set forth in article 1.7 of title 24, C.R.S.~~

~~(7)~~ (3) No suit, action, or other judicial or administrative proceeding lawfully commenced prior to July 1, 1994, or which could have been commenced prior to such date, by or against the department of local affairs, the state department of social services, the department of regulatory agencies, or the university of Colorado health sciences center, or any officer thereof in such officer's official capacity or in relation to the discharge of the official's duties, shall abate by reason of the transfer of duties and functions from said departments to the STATE department. ~~of health care policy and financing.~~

~~(8)~~ (4) The executive director, or a designee of the executive director, may accept, on behalf of and in the name of the state, gifts, donations, and grants for any purpose connected with the work and programs of the state department. Any property so given shall be held by the state treasurer, but the executive director, or the designee therefor, shall have the power to direct the disposition of any property so given for any purpose consistent with the terms and conditions under which such gift was created.

~~(9)~~ (5) The revisor of statutes is hereby authorized to change all references in the Colorado Revised Statutes to the department of local affairs, the state department of social services, the department of regulatory agencies, and the university of Colorado health sciences center from said references to the STATE department, ~~of health care policy and financing~~, as appropriate and with respect to the powers, duties, and functions transferred to the STATE department. ~~of health care policy and financing.~~ In connection with such authority, the revisor of statutes is hereby authorized to amend or delete provisions of the Colorado Revised Statutes so as to make the statutes consistent with the powers, duties, and functions transferred pursuant to this section.

~~(10)~~ (6) On and after July 1, 2003, the powers, duties, and functions relating to the old age pension health and medical care program and the supplemental old age pension health and medical care program, as specified in section ~~26-2-117, C.R.S.~~, 25.5-2-101, are transferred by a **type 2** transfer to the department of health care policy and financing.

25.5-1-106. Restructure of health and human services - development of plan - participation of department required. ~~The state department, in cooperation with the department of public health and environment and the department of human services, shall develop a plan for the restructuring of the health and human services delivery system in the state in accordance with article 1.7 of title 24, C.R.S.~~

25.5-1-107. Final agency action - administrative law judge - authority of executive director - direction to seek waiver of single state agency requirement.

(1) ~~(a)~~ The executive director may appoint one or more persons to serve as administrative law judges for the state department pursuant to section 24-4-105, C.R.S., and pursuant to part 10 of article 30 of title 24, C.R.S., subject to

appropriations made to the department of personnel. Except as provided in subsection (2) of this section, hearings conducted by the administrative law judge shall be considered initial decisions of the state department and shall be reviewed by the executive director or a designee of the executive director. In the event exceptions to the initial decision are filed pursuant to section 24-4-105 (14) (a) (I), C.R.S., such review shall be in accordance with section 24-4-105 (15), C.R.S. In the absence of any exception filed pursuant to section 24-4-105 (14) (a) (I), C.R.S., the executive director shall review the initial decision in accordance with a procedure adopted by the state board. Such procedure shall be consistent with federal mandates concerning the single state agency requirement. Review by the executive director in accordance with section 24-4-105 (15), C.R.S., or the procedure adopted by the state board pursuant to this section shall constitute final agency action. The administrative law judge may conduct hearings on appeals from decisions of county departments of social services brought by recipients of and applicants for public MEDICAL assistance and welfare which are required by law in order for the state to qualify for federal funds, and the administrative law judge may conduct other hearings for the state department. Notice of any such hearing shall be served at least ten days prior to such hearing.

~~(b) Repealed.~~

~~(c) The state department, in consultation with the office of administrative courts in the department of personnel, is directed by the general assembly to request any waivers from the appropriate federal authorities or agencies that have the authority to waive the single state agency requirement for the administration of a grant program with respect to the procedures for final agency action that are set forth in subsection (2) of this section. In developing the waiver request as required under this section, the state department shall consult with any appropriate advisory committees and other interested parties regarding the contents of the waiver request.~~

(2) Hearings initiated by a licensed or certified provider of services shall be conducted by an administrative law judge for the state department and shall be considered final agency action and subject to judicial review in accordance with the provisions of section 24-4-106, C.R.S., for any party, including the state department, which shall be considered a person for such purposes.

25.5-1-108. Executive director - rules. (1) The executive director shall have authority to promulgate rules in connection with the policies and procedures governing the administration of the department including, but not limited to, rules concerning the following:

(a) Matters of internal administration of the department, including organization, staffing, records, reports, systems, and procedures;

(b) Fiscal and personnel administration for the department;

(c) Accounting and fiscal reporting policies and procedures for disbursement of federal funds, contingency funds, and distribution of available appropriations;

(d) Such other rules relating to those functions the executive director is required to carry out pursuant to the provisions of this title.

(2) Nothing in this section shall be construed to affect any specific statutory provision granting rule-making authority in relation to a specific program to the executive director.

~~(3) Any rules adopted by the executive director shall not conflict with the plan for restructuring the health and human services delivery system, as set forth in article 1.7 of title 24, C.R.S.~~

~~(4) Notwithstanding any other provision of law that specifies a date by which rules are to be adopted by the medical services board created in part 3 of this article, until the members of the initial medical services board have been appointed, the executive director shall not adopt any rules or regulations other than temporary or emergency rules adopted in accordance with the provisions of section 24-4-103 (6), C.R.S.~~

25.5-1-109. Department of health care policy and financing cash fund. All moneys collected by the state department as fees or otherwise shall be transmitted to the state treasurer, who shall credit the same to the department of health care policy and financing cash fund, which fund is hereby created in the state treasury. Moneys in the fund shall be subject to annual appropriation by the general assembly for the direct and indirect costs of the state department's duties as provided by law.

25.5-1-110. Study of children's access to health care coverage - acceptance of donations - repeal. (Repealed)

25.5-1-111. [Relocated to 25.5-4-503] Waiver applications - authorization. The state department is authorized to apply for health insurance flexibility and accountability waivers that will enable the state to add more flexibility to Colorado's medicaid program and that will result in a cost-effective method of providing health care services to Coloradans.

25.5-1-112. Drug-purchasing pool - report - repeal. (Repealed)

25.5-1-113. [Relocated to 25.5-4-502] Federal authorization - repeal. (1) As used in this section, unless the context otherwise requires:

(a) "Eligible person" means a person who is eligible to receive services under part 6 of article 4 of title 26, C.R.S., or any other home- and community-based service waiver for which the state department has federal waiver authority.

(b) "Qualified services" means services provided under the eligible person's applicable waiver program and attendant support.

~~(2) The state department shall amend the necessary waivers to allow an eligible person to receive qualified services through the consumer-directed care service model.~~

~~(3) This section is repealed, effective July 1, 2007.~~

25.5-1-114. Grants-in-aid - county supervision. (1) THE STATE DEPARTMENT SHALL CONSULT WITH AND COORDINATE WITH THE COUNTIES BEFORE MAKING ANY

CHANGES THAT AFFECT COUNTY OPERATIONS IN THE IMPLEMENTATION OF THIS SECTION, WHEN POSSIBLE UNDER STATE STATUTES AND FEDERAL STATUTES AND REGULATIONS.

(2) IN ADMINISTERING ANY FUNDS APPROPRIATED OR MADE AVAILABLE TO THE STATE DEPARTMENT FOR MEDICAL ASSISTANCE ADMINISTRATION, THE STATE DEPARTMENT HAS THE POWER TO:

(a) REQUIRE AS A CONDITION FOR RECEIVING GRANTS-IN-AID THAT EACH COUNTY IN THIS STATE SHALL BEAR THE PROPORTION OF THE TOTAL EXPENSE OF FURNISHING MEDICAL ASSISTANCE ADMINISTRATION AS IS FIXED BY LAW RELATING TO SUCH ASSISTANCE;

(b) TERMINATE ANY GRANTS-IN-AID TO ANY COUNTY OF THIS STATE IF THE LAWS AND REGULATIONS PROVIDING SUCH GRANTS-IN-AID AND THE MINIMUM STANDARDS PRESCRIBED BY RULES OF THE STATE DEPARTMENT THEREUNDER ARE NOT COMPLIED WITH;

(c) UNDERTAKE FORTHWITH THE ADMINISTRATION OF ANY OR ALL MEDICAL ASSISTANCE WITHIN ANY COUNTY OF THIS STATE WHICH HAS HAD ANY OR ALL OF ITS GRANTS-IN-AID TERMINATED PURSUANT TO PARAGRAPH (b) OF THIS SUBSECTION (2); BUT THE COUNTY SHALL CONTINUE TO MEET THE REQUIREMENTS OF PARAGRAPH (a) OF THIS SUBSECTION (2);

(d) RECOVER ANY MONEYS OWED BY A COUNTY TO THE STATE BY REDUCING THE AMOUNT OF ANY PAYMENTS DUE FROM THE STATE IN CONNECTION WITH THE ADMINISTRATION OF MEDICAL ASSISTANCE;

(e) TAKE ANY OTHER ACTION WHICH MAY BE NECESSARY OR DESIRABLE FOR CARRYING OUT THE PROVISIONS OF THIS TITLE.

(3) THE STATE DEPARTMENT, UNDER THE SUPERVISION OF THE EXECUTIVE DIRECTOR, SHALL PROVIDE SUPERVISION OF COUNTY DEPARTMENTS FOR THE EFFECTIVE ADMINISTRATION OF MEDICAL ASSISTANCE AS SET OUT IN THE RULES OF THE EXECUTIVE DIRECTOR AND THE RULES OF THE STATE BOARD PURSUANT TO SECTION 25.5-1-301; EXCEPT THAT NOTHING IN THIS SUBSECTION (3) SHALL BE CONSTRUED TO ALLOW COUNTIES TO CONTINUE TO RECEIVE AN AMOUNT EQUAL TO THE INCREASED FUNDING IN THE EVENT THE SAID FUNDING IS NO LONGER AVAILABLE FROM THE FEDERAL GOVERNMENT.

25.5-1-115. Locating violators - recoveries. (1) THE EXECUTIVE DIRECTOR OF THE STATE DEPARTMENT, OR DISTRICT ATTORNEYS MAY REQUEST AND SHALL RECEIVE FROM DEPARTMENTS, BOARDS, BUREAUS, OR OTHER AGENCIES OF THE STATE OR ANY OF ITS POLITICAL SUBDIVISIONS, AND THE SAME ARE AUTHORIZED TO PROVIDE, SUCH ASSISTANCE AND DATA AS WILL ENABLE THE STATE DEPARTMENT AND COUNTY DEPARTMENTS PROPERLY TO CARRY OUT THEIR POWERS AND DUTIES TO LOCATE AND PROSECUTE ANY PERSON WHO HAS FRAUDULENTLY OBTAINED MEDICAL ASSISTANCE UNDER THIS TITLE. ANY RECORDS ESTABLISHED PURSUANT TO THE PROVISIONS OF THIS SECTION SHALL BE AVAILABLE ONLY TO THE STATE DEPARTMENT, THE DEPARTMENT OF HUMAN SERVICES, THE COUNTY DEPARTMENTS, THE ATTORNEY GENERAL, AND THE DISTRICT ATTORNEYS, COUNTY ATTORNEYS, AND

COURTS HAVING JURISDICTION IN FRAUD OR RECOVERY PROCEEDINGS OR ACTIONS.

(2) (a) ALL DEPARTMENTS AND AGENCIES OF THE STATE AND LOCAL GOVERNMENTS SHALL COOPERATE IN THE LOCATION AND PROSECUTION OF ANY PERSON WHO HAS FRAUDULENTLY OBTAINED MEDICAL ASSISTANCE UNDER THIS TITLE, AND, ON REQUEST OF THE COUNTY BOARD, THE COUNTY DIRECTOR, THE STATE DEPARTMENT, OR THE DISTRICT ATTORNEY OF ANY JUDICIAL DISTRICT IN THIS STATE, SHALL SUPPLY ALL INFORMATION ON HAND RELATIVE TO THE LOCATION, EMPLOYMENT, INCOME, AND PROPERTY OF SUCH PERSONS, NOTWITHSTANDING ANY OTHER PROVISION OF LAW MAKING SUCH INFORMATION CONFIDENTIAL, EXCEPT THE LAWS PERTAINING TO CONFIDENTIALITY OF ANY TAX RETURNS FILED PURSUANT TO LAW WITH THE DEPARTMENT OF REVENUE. THE DEPARTMENT OF REVENUE SHALL FURNISH AT NO COST TO INQUIRING DEPARTMENTS AND AGENCIES SUCH INFORMATION AS MAY BE NECESSARY TO EFFECTUATE THE PURPOSES OF THIS ARTICLE. THE PROCEDURES WHEREBY THIS INFORMATION WILL BE REQUESTED AND PROVIDED SHALL BE ESTABLISHED BY RULE OF THE STATE DEPARTMENT. THE STATE DEPARTMENT OR COUNTY DEPARTMENTS SHALL USE SUCH INFORMATION ONLY FOR THE PURPOSES OF ADMINISTERING MEDICAL ASSISTANCE UNDER THIS TITLE, AND THE DISTRICT ATTORNEY SHALL USE IT ONLY FOR THE PROSECUTION OF PERSONS WHO HAVE FRAUDULENTLY OBTAINED MEDICAL ASSISTANCE UNDER THIS TITLE, AND SHALL NOT USE THE INFORMATION, OR DISCLOSE IT, FOR ANY OTHER PURPOSE.

(b) (I) WHENEVER THE STATE DEPARTMENT, OR A DISTRICT ATTORNEY FOR THE STATE DEPARTMENT, OR THE STATE DEPARTMENT ON BEHALF OF A COUNTY DEPARTMENT, RECOVERS ANY AMOUNT OF FRAUDULENTLY OBTAINED MEDICAL ASSISTANCE FUNDS, THE FEDERAL GOVERNMENT SHALL BE ENTITLED TO A SHARE PROPORTIONATE TO THE AMOUNT OF FEDERAL FUNDS PAID UNLESS A DIFFERENT AMOUNT IS OTHERWISE PROVIDED BY FEDERAL LAW, THE STATE SHALL BE ENTITLED TO A SHARE PROPORTIONATE TO THE AMOUNT OF STATE FUNDS PAID AND SUCH ADDITIONAL AMOUNTS OF FEDERAL FUNDS RECOVERED AS PROVIDED BY FEDERAL LAW, AND THE COUNTY DEPARTMENT SHALL BE ENTITLED TO A SHARE PROPORTIONATE TO THE AMOUNT OF COUNTY FUNDS PAID UNLESS A DIFFERENT AMOUNT IS PROVIDED PURSUANT TO FEDERAL LAW OR THIS SECTION.

(II) WHENEVER A COUNTY DEPARTMENT, A COUNTY BOARD, A DISTRICT ATTORNEY, OR A STATE DEPARTMENT ON BEHALF OF A COUNTY DEPARTMENT RECOVERS ANY AMOUNT OF FRAUDULENTLY OBTAINED PUBLIC ASSISTANCE FUNDS IN THE FORM OF ASSISTANCE PAYMENTS OR MEDICAL ASSISTANCE, IT SHALL BE DEPOSITED IN THE COUNTY SOCIAL SERVICES FUND AND THE FEDERAL GOVERNMENT SHALL BE ENTITLED TO A SHARE PROPORTIONATE TO THE AMOUNT OF FEDERAL FUNDS PAID UNLESS A DIFFERENT AMOUNT IS PROVIDED FOR BY FEDERAL LAW, THE STATE SHALL BE ENTITLED TO A SHARE PROPORTIONATE TO ONE-HALF THE AMOUNT OF STATE FUNDS PAID, AND THE COUNTY SHALL BE ENTITLED TO A SHARE PROPORTIONATE TO THE AMOUNT OF COUNTY FUNDS PAID AND, IN ADDITION, A SHARE PROPORTIONATE TO ONE-HALF THE AMOUNT OF STATE FUNDS PAID.

(3) WHENEVER A COUNTY DEPARTMENT, A COUNTY BOARD, A DISTRICT ATTORNEY, OR THE STATE DEPARTMENT ON BEHALF OF THE COUNTY RECOVERS ANY AMOUNT OF MEDICAL ASSISTANCE PAYMENTS THAT WERE OBTAINED THROUGH UNINTENTIONAL CLIENT ERROR, THE FEDERAL GOVERNMENT SHALL BE ENTITLED TO A SHARE PROPORTIONATE TO THE AMOUNT OF FEDERAL FUNDS PAID, UNLESS A

DIFFERENT AMOUNT IS PROVIDED FOR BY FEDERAL LAW, THE STATE SHALL BE ENTITLED TO A SHARE PROPORTIONATE TO SEVENTY-FIVE PERCENT OF THE AMOUNT OF STATE FUNDS PAID, THE COUNTY SHALL BE ENTITLED TO A SHARE PROPORTIONATE TO THE AMOUNT OF COUNTY FUNDS PAID, IF ANY, AND, IN ADDITION, A SHARE PROPORTIONATE TO TWENTY-FIVE PERCENT OF THE AMOUNT OF STATE FUNDS PAID.

(4) ACTUAL COSTS AND EXPENSES INCURRED BY THE DISTRICT ATTORNEY'S OFFICE IN CARRYING OUT THE PROVISIONS OF SUBSECTION (2) OF THIS SECTION SHALL BE BILLED TO COUNTIES OR A COUNTY WITHIN THE JUDICIAL DISTRICT IN THE PROPORTIONS SPECIFIED IN SECTION 20-1-302, C.R.S. EACH COUNTY SHALL MAKE AN ANNUAL ACCOUNTING TO THE STATE DEPARTMENT ON ALL AMOUNTS RECOVERED.

25.5-1-116. Records confidential - authorization to obtain records of assets - release of location information to law enforcement agencies - outstanding felony arrest warrants. (1) THE STATE DEPARTMENT MAY ESTABLISH REASONABLE RULES TO PROVIDE SAFEGUARDS RESTRICTING THE USE OR DISCLOSURE OF INFORMATION CONCERNING APPLICANTS, RECIPIENTS, AND FORMER AND POTENTIAL RECIPIENTS OF MEDICAL ASSISTANCE TO PURPOSES DIRECTLY CONNECTED WITH THE ADMINISTRATION OF SUCH MEDICAL ASSISTANCE AND RELATED STATE DEPARTMENT ACTIVITIES AND COVERING THE CUSTODY, USE, AND PRESERVATION OF THE RECORDS, PAPERS, FILES, AND COMMUNICATIONS OF THE STATE AND COUNTY DEPARTMENTS. WHENEVER, UNDER PROVISIONS OF LAW, NAMES AND ADDRESSES OF APPLICANTS FOR, RECIPIENTS OF, OR FORMER AND POTENTIAL RECIPIENTS OF MEDICAL ASSISTANCE ARE FURNISHED TO OR HELD BY ANOTHER AGENCY OR DEPARTMENT OF GOVERNMENT, SUCH AGENCY OR DEPARTMENT SHALL BE REQUIRED TO PREVENT THE PUBLICATION OF LISTS THEREOF AND THEIR USES FOR PURPOSES NOT DIRECTLY CONNECTED WITH THE ADMINISTRATION OF SUCH MEDICAL ASSISTANCE.

(2) (a) (I) EXCEPT AS PROVIDED IN SUBPARAGRAPHS (II) AND (III) OF THIS PARAGRAPH (a), IT IS UNLAWFUL FOR ANY PERSON TO SOLICIT, DISCLOSE, OR MAKE USE OF OR TO AUTHORIZE, KNOWINGLY PERMIT, PARTICIPATE IN, OR ACQUIESCE IN THE USE OF ANY LISTS OR NAMES OF OR ANY INFORMATION CONCERNING PERSONS APPLYING FOR OR RECEIVING PUBLIC ASSISTANCE AND WELFARE DIRECTLY OR INDIRECTLY DERIVED FROM THE RECORDS, PAPERS, FILES, OR COMMUNICATIONS OF THE STATE OR COUNTY DEPARTMENTS OR SUBDIVISIONS OR AGENCIES THEREOF OR ACQUIRED IN THE COURSE OF THE PERFORMANCE OF OFFICIAL DUTIES. NO FINANCIAL INSTITUTION OR INSURANCE COMPANY THAT PROVIDES THE DATA, WHETHER CONFIDENTIAL OR NOT, REQUIRED BY THE STATE DEPARTMENT, IN ACCORDANCE WITH THE PROVISIONS OF THIS SUBSECTION (2), SHALL BE LIABLE FOR THE PROVISION OF THE DATA TO THE STATE DEPARTMENT NOR FOR ANY USE MADE THEREOF BY THE STATE DEPARTMENT.

(II) THE INFORMATION DESCRIBED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH (a) MAY BE DISCLOSED FOR PURPOSES DIRECTLY CONNECTED WITH THE ADMINISTRATION OF MEDICAL ASSISTANCE AND IN ACCORDANCE WITH THIS PARAGRAPH (a) AND PARAGRAPHS (b) AND (c) OF THIS SUBSECTION (2) AND WITH THE RULES OF THE STATE DEPARTMENT.

(III) (A) NOTWITHSTANDING ANY PROVISION OF STATE LAW TO THE CONTRARY

AND TO THE EXTENT ALLOWABLE UNDER FEDERAL LAW, AT THE REQUEST OF THE COLORADO BUREAU OF INVESTIGATION, THE STATE DEPARTMENT SHALL PROVIDE THE BUREAU WITH INFORMATION CONCERNING THE LOCATION OF ANY PERSON WHOSE NAME APPEARS IN THE DEPARTMENT'S RECORDS WHO IS THE SUBJECT OF AN OUTSTANDING FELONY ARREST WARRANT. UPON RECEIPT OF SUCH INFORMATION, IT SHALL BE THE RESPONSIBILITY OF THE BUREAU TO PROVIDE APPROPRIATE LAW ENFORCEMENT AGENCIES WITH LOCATION INFORMATION OBTAINED FROM THE STATE DEPARTMENT. LOCATION INFORMATION PROVIDED PURSUANT TO THIS SECTION SHALL BE USED SOLELY FOR LAW ENFORCEMENT PURPOSES. THE STATE DEPARTMENT AND THE BUREAU SHALL DETERMINE AND EMPLOY THE MOST COST-EFFECTIVE METHOD FOR OBTAINING AND PROVIDING LOCATION INFORMATION PURSUANT TO THIS SECTION. NEITHER THE STATE DEPARTMENT NOR ITS EMPLOYEES OR AGENTS SHALL BE LIABLE IN CIVIL ACTION FOR PROVIDING INFORMATION IN ACCORDANCE WITH THE PROVISIONS OF THIS SUB-SUBPARAGRAPH (A).

(B) AS USED IN SUB-SUBPARAGRAPH (A) OF THIS SUBPARAGRAPH (III), "LAW ENFORCEMENT AGENCY" MEANS ANY AGENCY OF THE STATE OR ITS POLITICAL SUBDIVISIONS THAT IS RESPONSIBLE FOR ENFORCING THE LAWS OF THIS STATE. "LAW ENFORCEMENT AGENCY" INCLUDES BUT IS NOT LIMITED TO ANY POLICE DEPARTMENT, SHERIFF'S DEPARTMENT, DISTRICT ATTORNEY'S OFFICE, THE OFFICE OF THE STATE ATTORNEY GENERAL, AND THE COLORADO BUREAU OF INVESTIGATION.

(b) BY SIGNING AN APPLICATION OR REDETERMINATION OF ELIGIBILITY FORM FOR MEDICAL ASSISTANCE, AN APPLICANT AUTHORIZES THE STATE DEPARTMENT TO OBTAIN RECORDS PERTAINING TO INFORMATION PROVIDED IN THAT APPLICATION OR REDETERMINATION OF ELIGIBILITY FORM FROM A FINANCIAL INSTITUTION, AS DEFINED IN SECTION 15-15-201 (4), C.R.S., OR FROM ANY INSURANCE COMPANY. THE APPLICATION OR REDETERMINATION OF ELIGIBILITY FORM SHALL CONTAIN LANGUAGE CLEARLY INDICATING THAT SIGNING CONSTITUTES SUCH AN AUTHORIZATION.

(c) (I) IN ORDER TO DETERMINE IF APPLICANTS FOR OR RECIPIENTS OF MEDICAL ASSISTANCE HAVE ASSETS WITHIN ELIGIBILITY LIMITS, THE STATE DEPARTMENT MAY PROVIDE A LIST OF INFORMATION IDENTIFYING THESE APPLICANTS OR RECIPIENTS TO ANY FINANCIAL INSTITUTION, AS DEFINED IN SECTION 15-15-201 (4), C.R.S., OR TO ANY INSURANCE COMPANY. THIS INFORMATION MAY INCLUDE IDENTIFICATION NUMBERS OR SOCIAL SECURITY NUMBERS. THE STATE DEPARTMENT MAY REQUIRE ANY SUCH FINANCIAL INSTITUTION OR INSURANCE COMPANY TO PROVIDE A WRITTEN STATEMENT DISCLOSING ANY ASSETS HELD ON BEHALF OF INDIVIDUALS ADEQUATELY IDENTIFIED ON THE LIST PROVIDED. BEFORE A TERMINATION NOTICE IS SENT TO THE RECIPIENT, THE COUNTY DEPARTMENT OR THE MEDICAL ASSISTANCE SITE IN VERIFYING THE ACCURACY OF THE INFORMATION OBTAINED AS A RESULT OF THE MATCH SHALL CONTACT THE RECIPIENT AND INFORM THE RECIPIENT OF THE APPARENT RESULTS OF THE COMPUTER MATCH AND GIVE THE RECIPIENT THE OPPORTUNITY TO EXPLAIN OR CORRECT ANY ERRONEOUS INFORMATION SECURED BY THE MATCH. THE REQUIREMENT TO RUN A COMPUTERIZED MATCH SHALL APPLY ONLY TO INFORMATION THAT IS ENTERED IN THE FINANCIAL INSTITUTION'S OR INSURANCE COMPANY'S DATA PROCESSING SYSTEM ON THE DATE THE MATCH IS RUN AND SHALL NOT BE DEEMED TO REQUIRE ANY SUCH INSTITUTION OR COMPANY TO CHANGE ITS DATA OR MAKE NEW ENTRIES FOR THE PURPOSE OF COMPARING IDENTIFYING INFORMATION. THE COST OF PROVIDING SUCH COMPUTERIZED MATCH

SHALL BE BORNE BY THE STATE DEPARTMENT.

(II) FOR THE FISCAL YEAR BEGINNING JULY 1, 1984, AND THEREAFTER, ALL FUNDS EXPENDED BY THE STATE DEPARTMENT TO PAY THE COST OF PROVIDING SUCH COMPUTERIZED MATCHES SHALL BE SUBJECT TO AN ANNUAL APPROPRIATION BY THE GENERAL ASSEMBLY.

(III) THE STATE DEPARTMENT MAY EXPEND FUNDS APPROPRIATED PURSUANT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH (c) IN AN AMOUNT NOT TO EXCEED THE AMOUNT OF ANNUALIZED GENERAL FUND SAVINGS THAT RESULT FROM THE TERMINATION OF RECIPIENTS FROM MEDICAL ASSISTANCE SPECIFICALLY DUE TO DISCLOSURE OF ASSETS PURSUANT TO THIS SUBSECTION (2).

(d) NO APPLICANT SHALL BE DENIED NOR ANY RECIPIENT DISCONTINUED DUE TO THE DISCLOSURE OF THEIR ASSETS UNLESS AND UNTIL THE COUNTY DEPARTMENT OR MEDICAL ASSISTANCE SITE HAS ASSURED THAT SUCH ASSETS TAKEN TOGETHER WITH OTHER ASSETS EXCEED THE LIMIT FOR ELIGIBILITY OF COUNTABLE ASSETS. ANY INFORMATION CONCERNING ASSETS FOUND MAY BE USED TO DETERMINE IF SUCH APPLICANT'S OR RECIPIENT'S ELIGIBILITY FOR OTHER MEDICAL ASSISTANCE IS AFFECTED.

(3) THE APPLICANT FOR OR RECIPIENT OF MEDICAL ASSISTANCE, OR HIS OR HER REPRESENTATIVE, SHALL HAVE AN OPPORTUNITY TO EXAMINE ALL APPLICATIONS AND PERTINENT RECORDS CONCERNING SAID APPLICANT OR RECIPIENT WHICH CONSTITUTE A BASIS FOR DENIAL, MODIFICATION, OR TERMINATION OF SUCH MEDICAL ASSISTANCE OR TO EXAMINE SUCH RECORDS IN CASE OF A FAIR HEARING.

(4) ANY PERSON WHO VIOLATES SUBSECTION (1) OR (2) OF THIS SECTION IS GUILTY OF A MISDEMEANOR AND, UPON CONVICTION THEREOF, SHALL BE PUNISHED BY A FINE OF NOT MORE THAN FIVE HUNDRED DOLLARS, OR BY IMPRISONMENT IN THE COUNTY JAIL FOR NOT MORE THAN THREE MONTHS, OR BY BOTH SUCH FINE AND IMPRISONMENT.

25.5-1-117. County departments - district departments. (1) EXCEPT AS PROVIDED IN SUBSECTION (2) OF THIS SECTION, THERE SHALL BE ESTABLISHED IN EACH COUNTY OF THE STATE A COUNTY DEPARTMENT OF SOCIAL SERVICES THAT SHALL CONSIST OF A COUNTY BOARD OF SOCIAL SERVICES, A COUNTY DIRECTOR OF SOCIAL SERVICES, AND ANY ADDITIONAL EMPLOYEES AS MAY BE NECESSARY FOR THE EFFICIENT PERFORMANCE OF PUBLIC ASSISTANCE, AS DEFINED IN SECTION 26-2-103 (7), C.R.S., AND MEDICAL ASSISTANCE.

(2) SINGLE ENTRY POINT AGENCIES ESTABLISHED PURSUANT TO PART 1 OF ARTICLE 6 OF THIS TITLE, OTHER THAN COUNTY DEPARTMENTS ACTING AS SINGLE ENTRY POINT AGENCIES, MAY ACT AS STATE DESIGNATED AGENCIES AND ARE HEREBY AUTHORIZED TO CARRY OUT FUNCTIONS AS SPECIFIED IN PART 1 OF ARTICLE 6 OF THIS TITLE THAT ARE OTHERWISE PERFORMED BY COUNTY DEPARTMENTS.

(3) WITH THE APPROVAL OF THE DEPARTMENT OF HUMAN SERVICES, TWO OR MORE COUNTIES MAY JOINTLY ESTABLISH A DISTRICT DEPARTMENT OF SOCIAL SERVICES. ALL DUTIES AND RESPONSIBILITIES FOR COUNTY DEPARTMENTS SET FORTH IN THIS TITLE SHALL ALSO APPLY TO DISTRICT DEPARTMENTS OF SOCIAL

SERVICES.

25.5-1-118. Duties of county departments, county directors, and district attorneys. (1) THE COUNTY DEPARTMENTS OR OTHER STATE DESIGNATED AGENCIES, WHERE APPLICABLE, SHALL SERVE AS AGENTS OF THE STATE DEPARTMENT AND SHALL BE CHARGED WITH THE ADMINISTRATION OF MEDICAL ASSISTANCE AND RELATED ACTIVITIES IN THE RESPECTIVE COUNTIES IN ACCORDANCE WITH THE RULES OF THE STATE DEPARTMENT.

(2) THE COUNTY DEPARTMENTS OR OTHER STATE DESIGNATED AGENCIES, WHERE APPLICABLE, SHALL REPORT TO THE STATE DEPARTMENT AT SUCH TIMES AND IN SUCH MANNER AND FORM AS THE STATE DEPARTMENT MAY FROM TIME TO TIME DIRECT.

(3) THE COUNTY DEPARTMENT OR OTHER STATE DESIGNATED AGENCIES, WHERE APPLICABLE, IN EACH COUNTY SHALL SUBMIT QUARTERLY AND ANNUALLY TO THE BOARD OF COUNTY COMMISSIONERS A BUDGET CONTAINING AN ESTIMATE AND SUPPORTING DATA SETTING FORTH THE AMOUNT OF MONEY NEEDED TO CARRY OUT THE PROVISIONS OF THIS TITLE.

25.5-1-119. County staff. THE COUNTY DIRECTOR, WITH THE APPROVAL OF THE COUNTY BOARD, SHALL APPOINT SUCH STAFF AS MAY BE NECESSARY AS DETERMINED BY THE STATE DEPARTMENT RULES TO ADMINISTER MEDICAL ASSISTANCE WITHIN THE COUNTY. THE STAFF SHALL BE APPOINTED AND SHALL SERVE IN ACCORDANCE WITH A MERIT SYSTEM FOR THE SELECTION, RETENTION, AND PROMOTION OF COUNTY DEPARTMENT EMPLOYEES AS DESCRIBED IN SECTION 26-1-120, C.R.S. THE SALARIES OF THE STAFF MEMBERS SHALL BE FIXED IN ACCORDANCE WITH THE RULES AND SALARY SCHEDULES PRESCRIBED BY THE STATE DEPARTMENT OR THE DEPARTMENT OF HUMAN SERVICES, WHICHEVER IS APPROPRIATE; EXCEPT THAT, ONCE A COUNTY TRANSFERS ITS COUNTY EMPLOYEES TO A SUCCESSOR MERIT SYSTEM AS PROVIDED IN SECTION 26-1-120, C.R.S., THE SALARIES SHALL BE FIXED BY THE COUNTY COMMISSIONERS.

25.5-1-120. Appropriations. (1) (a) FOR CARRYING OUT THE DUTIES AND OBLIGATIONS OF THE STATE DEPARTMENT AND COUNTY DEPARTMENTS UNDER THE PROVISIONS OF THIS TITLE AND FOR MATCHING SUCH FEDERAL FUNDS OR MEETING MAINTENANCE OF EFFORT REQUIREMENTS AS MAY BE AVAILABLE FOR PUBLIC ASSISTANCE AND WELFARE ACTIVITIES IN THE STATE, INCLUDING MEDICAL ASSISTANCE ADMINISTRATION AND RELATED ACTIVITIES, THE GENERAL ASSEMBLY, IN ACCORDANCE WITH THE CONSTITUTION AND LAWS OF THE STATE OF COLORADO, SHALL MAKE ADEQUATE APPROPRIATIONS FOR THE PAYMENT OF SUCH COSTS, PURSUANT TO THE BUDGET PREPARED BY THE EXECUTIVE DIRECTOR.

(b) IF THE FEDERAL LAW SHALL PROVIDE FEDERAL FUNDS, IN CASH OR IN ANOTHER FORM SUCH AS MEDICAL ASSISTANCE, NOT OTHERWISE PROVIDED FOR IN THIS TITLE, THE STATE DEPARTMENT IS AUTHORIZED TO MAKE SUCH PAYMENTS OR OFFER SUCH SERVICES IN ACCORDANCE WITH THE REQUIREMENTS ACCOMPANYING SAID FEDERAL FUNDS WITHIN THE LIMITS OF AVAILABLE STATE APPROPRIATIONS.

(c) WHEN THE EXECUTIVE DIRECTOR DETERMINES THAT ADEQUATE APPROPRIATIONS FOR THE PAYMENT OF THE COSTS DESCRIBED IN PARAGRAPH (a) OF

THIS SUBSECTION (1) HAVE NOT BEEN MADE AND THAT AN OVEREXPENDITURE OF AN APPROPRIATION WILL OCCUR BASED UPON THE STATE DEPARTMENT'S ESTIMATES, THE STATE BOARD MAY TAKE ACTIONS CONSISTENT WITH STATE AND FEDERAL LAW TO BRING THE RATE OF EXPENDITURE INTO LINE WITH AVAILABLE FUNDS. THE GENERAL ASSEMBLY DECLARES THAT CASE LOAD AND UTILIZATION BASED ON MEDICAL NECESSITY ARE LEGITIMATE REASONS FOR SUPPLEMENTAL FUNDING.

(2) THE GENERAL ASSEMBLY SHALL APPROPRIATE FROM THE GENERAL FUND TO THE STATE DEPARTMENT MONEYS FOR THE COSTS OF ADMINISTERING MEDICAL ASSISTANCE PROGRAMS AND THE STATE'S SHARE OF THE COSTS OF ADMINISTERING SUCH FUNCTIONS BY THE COUNTY DEPARTMENTS AMOUNTS SUFFICIENT FOR THE PROPER AND EFFICIENT PERFORMANCE OF THE DUTIES IMPOSED UPON THEM BY LAW, INCLUDING A LEGAL ADVISOR APPOINTED BY THE ATTORNEY GENERAL. THE GENERAL ASSEMBLY SHALL MAKE TWO SEPARATE APPROPRIATIONS, ONE FOR THE ADMINISTRATIVE COSTS OF THE STATE DEPARTMENT AND ANOTHER FOR THE ADMINISTRATIVE COSTS OF THE COUNTY DEPARTMENTS. ANY APPLICABLE MATCHING FEDERAL FUNDS SHALL BE APPORTIONED IN ACCORDANCE WITH THE FEDERAL REGULATIONS ACCOMPANYING SUCH FUNDS. ANY UNOBLIGATED AND UNEXPENDED BALANCES OF APPROPRIATED STATE GENERAL FUNDS REMAINING AT THE END OF EACH FISCAL YEAR SHALL BE CREDITED TO THE STATE GENERAL FUND.

(3) THE EXPENSES OF TRAINING PERSONNEL FOR SPECIAL SKILLS RELATING TO MEDICAL ASSISTANCE, AS SUCH EXPENSES SHALL BE DETERMINED AND APPROVED BY THE STATE DEPARTMENT, MAY BE PAID FROM STATE AND FEDERAL FUNDS AVAILABLE FOR SUCH TRAINING PURPOSES.

25.5-1-121. County expenditures - advancements - procedures. (1) FOR PURPOSES OF THIS ARTICLE, UNDER RULES OF THE STATE DEPARTMENT, ADMINISTRATIVE COSTS SHALL INCLUDE: SALARIES OF THE COUNTY DIRECTOR AND EMPLOYEES OF THE COUNTY DEPARTMENT STAFF ENGAGED IN THE PERFORMANCE OF MEDICAL ASSISTANCE ACTIVITIES; THE COUNTY'S PAYMENTS ON BEHALF OF SUCH EMPLOYEES FOR OLD AGE AND SURVIVORS' INSURANCE OR PURSUANT TO A COUNTY OFFICERS' AND EMPLOYEES' RETIREMENT PLAN AND FOR ANY HEALTH INSURANCE PLAN, IF APPROVED BY THE STATE DEPARTMENT; THE NECESSARY TRAVEL EXPENSES OF THE COUNTY BOARD AND THE ADMINISTRATIVE STAFF OF THE COUNTY DEPARTMENT IN THE PERFORMANCE OF THEIR DUTIES; NECESSARY TELEPHONE AND OTHER ELECTRONIC MEANS OF COMMUNICATION; NECESSARY EQUIPMENT AND SUPPLIES; NECESSARY PAYMENTS FOR POSTAGE AND PRINTING, INCLUDING THE PRINTING AND PREPARATION OF COUNTY WARRANTS REQUIRED FOR THE ADMINISTRATION OF THE COUNTY DEPARTMENT; AND SUCH OTHER ADMINISTRATIVE COSTS AS MAY BE APPROVED BY THE STATE DEPARTMENT; BUT ADVANCEMENTS FOR OFFICE SPACE, UTILITIES, AND FIXTURES MAY BE MADE FROM STATE FUNDS ONLY IF FEDERAL MATCHING FUNDS ARE AVAILABLE.

(2) NOTWITHSTANDING ANY OTHER PROVISION OF THIS ARTICLE, THE COUNTY DEPARTMENT MAY SPEND IN EXCESS OF TWENTY PERCENT OF ACTUAL COSTS FOR THE PURPOSE OF MATCHING FEDERAL FUNDS FOR THE ADMINISTRATION OF THE CHILD SUPPORT ENFORCEMENT PROGRAM OR FOR THE ADMINISTRATIVE COSTS OF ACTIVITIES INVOLVING FOOD STAMP, PUBLIC ASSISTANCE, OR MEDICAL ASSISTANCE FRAUD INVESTIGATIONS OR PROSECUTIONS.

25.5-1-122. County appropriation increases - limitations. (1) BEGINNING IN CALENDAR FISCAL YEAR 1994 AND FOR EACH CALENDAR FISCAL YEAR THEREAFTER TO AND INCLUDING CALENDAR FISCAL YEAR 1997, THE BOARD OF COUNTY COMMISSIONERS IN EACH COUNTY OF THIS STATE SHALL ANNUALLY APPROPRIATE FUNDS FOR THE COUNTY SHARE OF THE ADMINISTRATIVE COSTS OF MEDICAL ASSISTANCE IN THE COUNTY IN AN AMOUNT EQUAL TO THE ACTUAL COUNTY SHARE FOR THE PREVIOUS FISCAL YEAR ADJUSTED BY AN AMOUNT EQUAL TO THE ACTUAL COUNTY SHARE FOR THE PREVIOUS FISCAL YEAR MULTIPLIED BY THE PERCENTAGE OF CHANGE IN PROPERTY TAX REVENUE.

(2) FOR THE PURPOSES OF THIS SECTION:

(a) "COUNTY SHARE" MEANS THE ACTUAL AMOUNT OF THE COUNTY SHARE FOR THE PREVIOUS FISCAL YEAR. "COUNTY SHARE" SHALL NOT INCLUDE:

(I) THE AMOUNT EXPENDED BY THE COUNTY FROM THE COUNTY CONTINGENCY FUND PURSUANT TO SECTION 26-1-126, C.R.S.;

(II) THE AMOUNT EXPENDED BY THE COUNTY FOR GENERAL ASSISTANCE PURSUANT TO PART 1 OF ARTICLE 17 OF TITLE 30, C.R.S.; AND

(III) THE AMOUNT EXPENDED BY THE COUNTY FOR PROGRAMS OR SERVICES PROVIDED BY THE COUNTY ON ITS OWN, WITHOUT REQUIREMENTS OR FUNDING FROM ANY OTHER GOVERNMENTAL AGENCY.

(b) "PERCENTAGE OF CHANGE IN PROPERTY TAX REVENUE" MEANS THE DIFFERENCE BETWEEN THE TOTAL PROPERTY TAX LEVIED FOR THE PREVIOUS FISCAL YEAR LESS THE AMOUNT LEVIED FOR DEBT SERVICE FOR THE PREVIOUS FISCAL YEAR AND THE TOTAL PROPERTY TAX LEVIED FOR THE YEAR FOR WHICH THE PERCENTAGE OF CHANGE IN TAX REVENUE IS BEING CALCULATED LESS THE AMOUNT LEVIED FOR DEBT SERVICE FOR THE YEAR IN WHICH THE PERCENTAGE OF CHANGE IN TAX REVENUE IS BEING CALCULATED DIVIDED BY THE TOTAL PROPERTY TAX LEVIED FOR THE PREVIOUS FISCAL YEAR LESS THE AMOUNT LEVIED FOR DEBT SERVICE FOR THE PREVIOUS FISCAL YEAR.

(3) NOTWITHSTANDING THE PROVISIONS OF SECTION 25.5-1-121, A COUNTY IN THE STATE SHALL NOT BE REQUIRED TO CONTRIBUTE MORE THAN THE AMOUNT SET FORTH IN SUBSECTION (1) OF THIS SECTION IN ANY FISCAL YEAR. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO LIMIT THE ABILITY OF A COUNTY TO ESTABLISH PROGRAMS OR SERVICES PROVIDED BY THE COUNTY ON ITS OWN, WITHOUT REQUIREMENTS OR FUNDING FROM ANY OTHER GOVERNMENTAL AGENCY.

(4) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (1) OF THIS SECTION, A COUNTY IN THIS STATE SHALL NOT BE REQUIRED TO CONTRIBUTE AN AMOUNT WHICH EXCEEDS THE TOTAL SOCIAL SERVICES MILL LEVY THE COUNTY MAY ASSESS PURSUANT TO SECTION 26-1-125, C.R.S.

(5) ANY AMOUNTS REMAINING IN THE COUNTY SOCIAL SERVICES FUND CREATED IN SECTION 26-1-123, C.R.S., AT THE END OF ANY FISCAL YEAR SHALL REMAIN IN THE COUNTY FUND FOR EXPENDITURE AS DETERMINED BY THE BOARD OF COUNTY COMMISSIONERS FOR ADMINISTRATIVE COSTS OF PUBLIC ASSISTANCE, MEDICAL

ASSISTANCE, AND FOOD STAMPS, AND PROGRAM COSTS OF PUBLIC ASSISTANCE AND FOOD STAMPS.

(6) THE LIMITATION SET FORTH IN THIS SECTION ON THE INCREASE IN THE COUNTY SHARE OF THE ADMINISTRATIVE COSTS OF MEDICAL ASSISTANCE WILL RESULT IN INCREASED COSTS TO THE STATE. BY MAKING STATE FUNDS AVAILABLE, THE STATE IS ENCOURAGING COUNTIES NOT TO EXERCISE ANY RIGHT A COUNTY MAY HAVE PURSUANT TO SECTION 20 (9) OF ARTICLE X OF THE COLORADO CONSTITUTION TO REDUCE OR END ITS SHARE OF THE COSTS OF MEDICAL ASSISTANCE ADMINISTRATION FOR THE COUNTY FOR THREE FISCAL YEARS FOLLOWING THE FISCAL YEAR IN WHICH THE STATE FUNDS ARE RECEIVED. IF A COUNTY ACCEPTS FUNDS FROM THE STATE BASED ON THE LIMITATION PROVIDED IN THIS SECTION FOR ANY FISCAL YEAR, THE COUNTY AGREES NOT TO EXERCISE ANY RIGHTS THE COUNTY MAY HAVE TO REDUCE OR END ITS SHARE OF THE COSTS OF MEDICAL ASSISTANCE ADMINISTRATION FOR THE FISCAL YEAR IN WHICH THE FUNDS ARE ACCEPTED. NOTHING IN THIS SUBSECTION (6) OR ANY AGREEMENT PURSUANT TO THIS SUBSECTION (6) SHALL BE CONSTRUED TO AFFECT THE EXISTENCE OR STATUS OF ANY RIGHTS ACCRUING TO THE STATE OR ANY COUNTY PURSUANT TO SECTION 20 (9) OF ARTICLE X OF THE COLORADO CONSTITUTION.

SECTION 2. Part 2 of article 1 of title 25.5, Colorado Revised Statutes, is amended to read:

PART 2
PROGRAMS TO BE ADMINISTERED
BY THE DEPARTMENT

25.5-1-201. Programs to be administered by the department of health care policy and financing. (1) Programs to be administered and functions to be performed by the department of health care policy and financing shall be as follows:

~~(a) and (b) Repealed:~~

~~(c)~~ (a) The "Colorado Medical Assistance Act", as specified in ~~article 4 of title 26, C.R.S.~~ ARTICLES 4, 5, AND 6 OF THIS TITLE;

~~(d)~~ (b) The ~~"Reform Act for the Provision of Health Care for the Medically Indigent"~~ "COLORADO INDIGENT CARE PROGRAM", as specified in ~~article 15 of title 26, C.R.S.~~ PART 1 OF ARTICLE 3 OF THIS TITLE;

~~(e)~~ Adult foster care, as specified in section 26-2-122.3, C.R.S.;

~~(f)~~ Home care allowance, as specified in section 26-2-122.3, C.R.S.;

~~(g)~~ The treatment program for high-risk pregnant women created pursuant to section 25-1-212, C.R.S., and as specified in section 26-4-508.4, C.R.S.;

~~(h) Repealed:~~

~~(i)~~ The "Hospital Efficiency and Cooperation Act", as specified in part 5 of this article;

~~(j)~~ (c) Effective July 1, 1996, school entry immunization, as specified in part 9 of article 4 of title 25, C.R.S. Commencing on and after the fiscal year beginning July 1, 1996, the state department is authorized to contract with the department of public health and environment for the purpose of enforcing the school entry immunization requirements.

~~(k)~~ The consumer-directed attendant support pilot program authorized in section ~~26-4-903, C.R.S.;~~

~~(l)~~ (d) The health and medical care program for recipients of aid to the needy disabled, as specified in section ~~26-2-119.5, C.R.S.;~~ 25.5-2-102;

~~(m)~~ (e) The "Children's Basic Health Plan Act", as specified in ~~article 19 of title 26, C.R.S.;~~ ARTICLE 8 OF THIS TITLE; and

~~(n)~~ (f) The old age pension health and medical care program and the supplemental old age pension health and medical care program, as specified in section ~~26-2-117, C.R.S.;~~ 25.5-2-101.

~~25.5-1-202. Birth-related cost recovery program - legislative declaration - waiver - duties of state department - repeal. (Repealed)~~

SECTION 3. Part 3 of article 1 of title 25.5, Colorado Revised Statutes, is amended to read:

PART 3
MEDICAL SERVICES BOARD

25.5-1-301. Medical services board - creation. (1) There is hereby created in the STATE department of ~~health care policy and financing~~ a medical services board, referred to in this part 3 as the "board", which shall consist of eleven members appointed by the governor with the consent of the senate. The governor shall appoint persons to the board who have knowledge of medical assistance programs, and one or more of the appointments may include a person or persons who have received services through programs administered by the department within two years of the date of appointment. No more than six members of the board shall be members of the same political party. Of the eleven members appointed to the board, at least one shall be appointed from each congressional district.

(2) Members shall serve at the pleasure of the governor for a term of four years; except that, of the members first appointed, three shall serve for a term of two years and three shall serve for a term of three years. On July 1, 2001, the governor shall appoint one member from the private sector to the board who shall have experience with the delivery of health care, who shall be appointed for a term of two years, and one member who shall have experience or expertise in caring for medically underserved children, who shall be appointed for a term of three years.

(3) Members shall receive no compensation but shall be reimbursed for reasonable and necessary actual expenses incurred in the performance of their official duties as members of the board.

(4) Vacancies on the board shall be filled by appointment of the governor for the remainder of any unexpired term.

25.5-1-302. Medical services board - organization. (1) The board shall elect from its members a president, a vice-president, and such other board officers as it shall determine. All board officers shall hold their offices at the pleasure of the board.

(2) Regular meetings of the board shall be held not less than once every three months at such times as may be fixed by resolution of the board. All meetings of the board, in every suit and proceeding, shall be considered to have been duly called and regularly held and all orders and proceedings of the board to have been authorized, unless the contrary is proven.

(3) The board shall adopt, and at any time may amend, bylaws in relation to its meetings and the transaction of its business. A majority shall constitute a quorum of the board. The vote of a majority OF A QUORUM of the board shall constitute the action of the board. The board shall act only by resolution adopted at a duly called meeting of the board, and no individual of the board shall exercise any individual administrative authority with respect to the department.

25.5-1-303. Powers and duties of the board - scope of authority - rules. (1) The board shall have the authority set forth in subsection (3) of this section over the following programs administered by the STATE department:

(a) The "Colorado Medical Assistance Act", as specified in ~~article 4 of title 26, C.R.S. ARTICLES 4, 5, AND 6 OF THIS TITLE;~~

(b) The ~~"Reform Act for the Provision of Health Care for the Medically Indigent"~~ "COLORADO INDIGENT CARE PROGRAM", as specified in ~~article 15 of title 26, C.R.S. PART 1 OF ARTICLE 3 OF THIS TITLE;~~

~~(c) Adult foster care, as specified in section 26-2-122.3, C.R.S.;~~

~~(d) Home care allowance, as specified in section 26-2-122.3, C.R.S.;~~

~~(e)~~ (c) The health and medical care program for recipients of aid to the needy disabled, as specified in section ~~26-2-119.5, C.R.S.~~ 25.5-2-102;

~~(f)~~ (d) The "Children's Basic Health Plan Act", as specified in ~~article 19 of title 26, C.R.S.~~ ARTICLE 8 OF THIS TITLE;

(e) THE OLD AGE PENSION HEALTH AND MEDICAL CARE PROGRAM AND THE SUPPLEMENTAL OLD AGE PENSION HEALTH AND MEDICAL CARE PROGRAM, AS SPECIFIED IN SECTION 25.5-2-101.

(2) Nothing in this section shall be construed to affect any specific statutory provision granting rule-making authority to the board in relation to a specific program.

(3) The board shall adopt rules in connection with the programs set forth in

subsection (1) of this section governing the following:

(a) The implementation of legislative and departmental policies and procedures for such programs; except that no rules shall be promulgated for any policy or procedure which governs the administration of the STATE department as specified in section 25.5-1-108 (1);

(b) The establishment of eligibility requirements for persons receiving services from the STATE department;

(c) The establishment of the type of benefits that a recipient of services may obtain if eligibility requirements are met, subject to the authorization, requirements, and availability of such benefits;

(d) The requirements, obligations, and rights of clients and recipients;

(e) The establishment of a procedure to resolve disputes that may arise between clients and the STATE department or clients and providers;

(f) The requirements, obligations, and rights of providers, including policies and procedures related to provider payments that may affect client benefits;

(g) The establishment of a procedure to resolve disputes that may arise between providers and between the STATE department and providers.

~~(4) (Deleted by amendment, L. 2003, p. 2584, § 4, effective July 1, 2003.)~~

~~(5)~~ (4) At the request of the executive director, the board shall advise the executive director as to any proposed policies or rules governing programs administered by the STATE department that are not set forth in subsection (1) of this section.

~~(6)~~ (5) The board shall have no authority over the revenue of the STATE department.

~~(7) The board shall report annually to the joint budget committee of the general assembly and the health, environment, welfare, and institutions committees of the house of representatives and the senate on the implementation and performance of the children's basic health plan program, including but not limited to the extent to which private sector strategies and resources are effectively used as part of the program.~~

~~(8)(a) The board shall adopt rules in connection with the old age pension health and medical care program and the supplemental old age pension health and medical care program established in section 26-2-117, C.R.S.~~

~~(b)~~ (6) All rules and orders of the department of human services in connection with the old age pension health and medical care program and the supplemental old age pension health and medical care program shall continue to be effective until revised, amended, repealed, or nullified pursuant to law.

(7) THE RULES ISSUED BY THE STATE BOARD SHALL BE BINDING UPON THE COUNTY DEPARTMENTS. AT ANY PUBLIC HEARING RELATING TO A PROPOSED RULE MAKING, INTERESTED PERSONS SHALL HAVE THE RIGHT TO PRESENT THEIR DATA, VIEWS, OR ARGUMENTS ORALLY. PROPOSED RULES OF THE STATE BOARD SHALL BE SUBJECT TO THE PROVISIONS OF SECTION 24-4-103, C.R.S.

(8) TO THE EXTENT THAT RULES ARE PROMULGATED BY THE STATE BOARD OF HUMAN SERVICES FOR PROGRAMS OR PROVIDERS THAT RECEIVE EITHER MEDICAID ONLY OR BOTH MEDICAID AND NON-MEDICAID FUNDING, THE RULES SHALL BE DEVELOPED IN COOPERATION WITH THE STATE DEPARTMENT AND SHALL NOT CONFLICT WITH STATE STATUTES OR FEDERAL STATUTES OR REGULATIONS.

25.5-1-304. Repeal of part. ~~This part 3 is repealed, effective July 1, 2007.~~

SECTION 4. Repeal. Part 5 of article 1 of title 25.5, Colorado Revised Statutes, is repealed.

SECTION 5. Article 2 of title 25.5, Colorado Revised Statutes, is amended CONTAINING RELOCATED PROVISIONS, WITH AMENDMENTS, to read:

ARTICLE 2
~~Poison Control Act~~
State-funded Health and Medical Care

~~**25.5-2-101 to 25.5-2-104. (Repealed)**~~

25.5-2-101. [Formerly 26-2-117] Old age pension health and medical care fund - supplemental old age pension health and medical care fund. (1) The general assembly hereby finds that when the old age pension program was established in 1936, it served both the middle-income and indigent elderly population and that there were no federal programs available to assist the elderly impoverished population. The general assembly finds that the population currently served by the old age pension is the indigent elderly population only and that there are significant federal assistance programs for the elderly in this country that did not exist when the old age pension program was created. Moreover, the general assembly finds that the health and medical care fund created in the state constitution now serves only those old age pension recipients who do not qualify for social security benefits and therefore are not medicaid-eligible. The general assembly also finds that the constitutional limitation on costs that may be annually incurred by the old age pension health and medical care program no longer reflect the actual cost of serving this growing population. The general assembly also notes that the state on several occasions has had to limit the types of medical services available in order to meet this constitutional limit. The general assembly, therefore, finds that there is a need to supplement the funds available for health and medical care for this group of old age pension recipients. The general assembly finds that while the state constitution limits the costs of the original health and medical care program to ten million dollars annually, it does not preclude the general assembly from creating a supplemental health program. The general assembly also finds that section 2 of article XXIV of the state constitution directs that sales and use taxes be used to fund programs and services for older citizens and establishes a constitutional priority to fund such services and thus, it is fitting that a small portion of the sales and use tax

revenue be allocated to fund a separate supplemental health and medical care program to serve the needs of the old age pension recipients who qualify for the health and medical care program.

(2) Any moneys remaining in the state old age pension fund after full payment of basic minimum awards to qualified old age pension recipients and after establishment and maintenance of the old age pension stabilization fund in the amount of five million dollars shall be transferred to a fund to be known as the old age pension health and medical care fund, which is hereby created. The ~~department of health care policy and financing~~ STATE BOARD shall establish and promulgate rules for administration of a program to provide health and medical care to persons who qualify to receive old age pensions and who are not patients in an institution for tuberculosis or mental diseases. The costs of such program, not to exceed ten million dollars in any fiscal year, shall be defrayed from such health and medical care fund, but all moneys available, accrued or accruing, received or receivable, in said health and medical care fund in excess of ten million dollars in any fiscal year shall be transferred to the general fund of the state to be used pursuant to law. Moneys in the old age pension health and medical care fund shall be subject to annual appropriation by the general assembly.

(3) There is hereby established in the STATE ~~department of health care policy and financing~~ a supplemental health and medical care program to provide health and medical care to persons who qualify to receive old age pensions and who are not patients in an institution for tuberculosis or mental diseases. The ~~department of health care policy and financing~~ STATE BOARD shall promulgate rules for administration of the supplemental health and medical care program, which shall be based upon and shall provide the same types of services that are provided pursuant to the rules for administration of the health and medical care program described in subsection (2) of this section. When the costs of providing health and medical care in a particular fiscal year to such old age pension recipients exceed the amount available in that fiscal year from the old age pension health and medical care fund created in subsection (2) of this section, the medical care for such recipients shall be provided by the supplemental health and medical care program. The costs of the supplemental health and medical care program shall be paid out of the supplemental old age pension health and medical care fund, which is hereby created in the state treasury. The supplemental old age pension health and medical care fund, ~~herein~~ referred to as the "supplemental fund", shall consist of state sales and use tax revenues allocated to the supplemental fund pursuant to the provisions of section 39-26-123 (3), C.R.S., and any moneys appropriated to the supplemental fund by the general assembly. The general assembly may make annual appropriations or supplemental appropriations to the supplemental fund if it determines that the moneys in the old age pension health and medical care fund created in subsection (2) of this section will be insufficient to meet the health and medical needs of old age pension recipients for a particular fiscal year. Moneys in the supplemental fund shall be subject to annual appropriation by the general assembly. At the end of any fiscal year, any unexpended and unencumbered moneys remaining in the supplemental fund shall remain therein and shall not be credited or transferred to the general fund or any other fund. The supplemental health and medical care program and the supplemental fund shall be effective in fiscal year 2002-03.

25.5-2-102. [Formerly 26-2-119.5] Health and medical care program - aid

to the needy disabled. (1) The STATE department, ~~of health care policy and financing~~, in consultation with the department of human services, shall develop and administer a program to rank health and medical care needs and to provide health and medical care based on such ranking to persons who qualify to receive aid to the needy disabled and who are not receiving medical assistance. Such program, referred to in this section as the "health and medical care program" shall evaluate and rank the health and medical care needs of all persons who qualify for aid to the needy disabled on or after January 1, 2002, and shall be provided to qualifying persons only during the interim period after the person qualifies for the aid to the needy disabled program and until the determination is made as to whether the person qualifies for federal supplemental security income benefits.

(2) The state treasurer shall transfer moneys recovered pursuant to section 3 of article XXIV of the state constitution to the medically correctable program and to the health and medical care program if such transfer is authorized by the voters. The costs of the health and medical care program shall be funded annually from appropriations made by the general assembly from such transferred moneys and from any other sources. The health and medical care program shall commence January 1, 2002, and shall apply to persons who apply for aid to the needy disabled on and after said date and who meet eligibility requirements for medical care services as specified by the STATE board ~~of medical services~~ by rule.

SECTION 6. Article 3 of title 25.5, Colorado Revised Statutes, is amended CONTAINING RELOCATED PROVISIONS, WITH AMENDMENTS, to read:

ARTICLE 3
~~Comprehensive Primary Care~~
Indigent Care

PART 1
~~REFORM ACT FOR THE PROVISION OF HEALTH CARE~~
~~FOR THE MEDICALLY INDIGENT~~
COLORADO INDIGENT CARE PROGRAM

25.5-3-101. [Formerly 26-15-101] Short title. This part 1 shall be known and may be cited as the "~~Reform Act for the Provision of Health Care for the Medically Indigent~~" "COLORADO INDIGENT CARE PROGRAM".

25.5-3-102. [Formerly 26-15-102] Legislative declaration. (1) The general assembly hereby determines, finds, and declares that:

(a) The state has insufficient resources to pay for all medical services for persons who are indigent and must therefore allocate available resources in a manner ~~which~~ THAT will provide treatment of those conditions constituting the most serious threats to the health of such medically indigent persons, as well as increase access to primary medical care to prevent deterioration of the health conditions among medically indigent people; and

(b) Such allocation of resources will require the prioritization of medical services by providers and the coordination of administration and delivery of medical services.

(2) The general assembly further determines, finds, and declares that the eligibility of medically indigent persons to receive medical services rendered under the conditions specified in subsection (1) of this section exists only to the extent of available appropriations, as well as to the extent of the individual provider facility's physical, staff, and financial capabilities. The general assembly also recognizes that the program for the medically indigent is a partial solution to the health care needs of Colorado's medically indigent citizens. Therefore, medically indigent persons accepting medical services from such program shall be subject to the limitations and requirements imposed in this ~~article~~ PART 1.

25.5-3-103. [Formerly 26-15-103] Definitions. As used in this part 1, unless the context otherwise requires:

(1) "Emergency care" means treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus.

~~(1.5)~~ (2) "Executive director" means the executive director of the STATE department. ~~of health care policy and financing.~~

~~(2)~~ (3) "General provider" means any general hospital, birth center, or community health clinic licensed or certified by the department of public health and environment pursuant to section 25-1.5-103 (1) (a) (I) or (1) (a) (II), C.R.S., any health maintenance organization issued a certificate of authority pursuant to section 10-16-402, C.R.S., and the health sciences center when acting pursuant to section ~~26-15-106 (5) (a) (I) or (5) (a) (II) (A)~~ 25.5-3-108 (5) (a) (I) OR (5) (a) (II) (A). For the purposes of the program, "general provider" includes associated physicians.

~~(3)~~ (4) "Health sciences center" means the schools of medicine, dentistry, nursing, and pharmacy established by the regents of the university of Colorado under section 5 of article VIII of the Colorado constitution.

~~(4)~~ (5) "Program" means the program for the medically indigent established by section ~~26-15-104~~ 25.5-3-104.

~~(4.5)~~ "State department" means the department of health care policy and financing.

~~(5)~~ (6) "University hospital" means the university hospital operated pursuant to article 21 of title 23, C.R.S.

25.5-3-104. [Formerly 26-15-104] Program for the medically indigent established. A program for the medically indigent is hereby established, to commence July 1, 1983, which shall be administered by the STATE department, ~~of health care policy and financing~~, to provide payment to providers for the provision of medical services to eligible persons who are medically indigent. The ~~department of health care policy and financing~~ STATE BOARD may promulgate ~~such rules and regulations~~ as are necessary for the implementation of this part 1 in accordance with article 4 of title 24, C.R.S.

25.5-3-105. [Formerly 26-15-104.3] Eligibility of legal immigrants for services. A legal immigrant who is a resident of the state of Colorado shall be eligible to receive services under this part 1 so long as he or she meets the eligibility requirements. As used in this section, "legal immigrant" has the same meaning as described in section ~~26-4-103 (8.5)~~ 25.5-4-103 (10). As a condition of eligibility for services under this part 1, a legal immigrant shall agree to refrain from executing an affidavit of support for the purpose of sponsoring an alien on or after July 1, 1997, under rules promulgated by the immigration and naturalization service, OR ANY SUCCESSOR AGENCY, during the pendency of such legal immigrant's receipt of services under this part 1. Nothing in this section shall be construed to affect a legal immigrant's eligibility for services under this part 1 based upon such legal immigrant's responsibilities under an affidavit of support entered into before July 1, 1997.

25.5-3-106. [Formerly 26-15-104.5] No public funds for abortion - exception.
(1) It is the purpose of this section to implement the provisions of amendment 3 to article V of the Colorado constitution, adopted by the registered electors of the state of Colorado at the general election November 6, 1984, which prohibits the use of public funds by the state of Colorado or its agencies or political subdivisions to pay or otherwise reimburse, directly or indirectly, any person, agency, or facility for any induced abortion.

(2) If every reasonable effort has been made to preserve the lives of a pregnant woman and her unborn child, then public funds may be used pursuant to this section to pay or reimburse for necessary medical services, not otherwise provided for by law.

(3) (a) Except as provided in paragraph (b) of this subsection (3), any necessary medical services performed pursuant to this section shall be performed only in a licensed health care facility by a provider who is a licensed physician.

(b) However, such services may be performed in other than a licensed health care facility if, in the medical judgment of the attending physician, the life of the pregnant woman or her unborn child is substantially threatened and a transfer to a licensed health care facility would further endanger the life of the pregnant woman or her unborn child. Such medical services may be performed in other than a licensed health care facility if the medical services are necessitated by a life-endangering circumstance described in subparagraph (II) of paragraph (b) of subsection (6) of this section and if there is no licensed health care facility within a thirty-mile radius of the place where such medical services are performed.

(4) (a) Any physician who renders necessary medical services pursuant to subsection (2) of this section shall report the following information to the state department:

(I) The age of the pregnant woman and the gestational age of the unborn child at the time the necessary medical services were performed;

(II) The necessary medical services which were performed;

(III) The medical condition which necessitated the performance of necessary

medical services;

(IV) The date such necessary medical services were performed and the name of the facility in which such services were performed.

(b) The information required to be reported pursuant to paragraph (a) of this subsection (4) shall be compiled by the state department and such compilation shall be an ongoing public record; except that the privacy of the pregnant woman and the attending physician shall be preserved.

(5) For purposes of this section, pregnancy is a medically diagnosable condition.

(6) For the purposes of this section:

(a) (I) "Death" means:

(A) The irreversible cessation of circulatory and respiratory functions; or

(B) The irreversible cessation of all functions of the entire brain, including the brain stem.

(II) A determination of death under this section shall be in accordance with accepted medical standards.

(b) "Life-endangering circumstance" means:

(I) The presence of a medical condition, other than a psychiatric condition, as determined by the attending physician, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term;

(II) The presence of a lethal medical condition in the unborn child, as determined by the attending physician and one other physician, which would result in the impending death of the unborn child during the term of pregnancy or at birth; or

(III) The presence of a psychiatric condition which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term. In such case, unless the pregnant woman has been receiving prolonged psychiatric care, the attending licensed physician shall obtain consultation from a licensed physician specializing in psychiatry confirming the presence of such a psychiatric condition. The attending physician shall report the findings of such consultation to the state department.

(c) "Necessary medical services" means any medical procedures deemed necessary to prevent the death of a pregnant woman or her unborn child due to life-endangering circumstances.

(7) If any provision of this section or application thereof is held invalid, such invalidity shall not affect other provisions or applications of this section which can be given effect without the invalid provision or application and, to this end, provisions of this section are declared severable.

(8) Use of the term "unborn child" in this section is solely for the purposes of facilitating the implementation of section 50 of article V of the state constitution and its use shall not affect any other law or statute nor shall it create any presumptions relating to the legal status of an unborn child or create or affect any distinction between the legal status of an unborn child and the legal status of a fetus.

(9) This section shall be repealed if section 50 of article V of the Colorado constitution is repealed.

25.5-3-107. [Formerly 26-15-105] Report concerning the program. The executive director shall prepare an annual report concerning the status of the medically indigent program to be submitted to the ~~health, environment, welfare, and institutions~~ HEALTH AND HUMAN SERVICES committees of the senate and the house of representatives, OR ANY SUCCESSOR COMMITTEES, no later than February 1 of each year. The report shall be prepared following consultation with providers in the program, state department personnel, and other agencies, organizations, or individuals as the executive director deems appropriate in order to obtain comprehensive and objective information about the program.

25.5-3-108. [Formerly 26-15-106] Responsibility of the department of health care policy and financing - provider reimbursement. (1) The state department shall be responsible for:

(a) Execution of such contracts with providers for partial reimbursement of costs for medical services rendered to the medically indigent as the state department shall determine are necessary for the program;

(b) Promulgation of such reasonable rules as are necessary for the program; and

(c) Submission of the report required in section ~~26-15-105~~ 25.5-3-107.

(2) The contracts required by paragraph (a) of subsection (1) of this section shall be negotiated between the state department and the various general providers, as defined in section ~~26-15-103 (2)~~ 25.5-3-103 (3), and shall include contracts with providers to provide tertiary or specialized services. The state department may award such contracts upon a determination that it would not be cost effective nor result in adequate quality of care for such services to be developed by the contract providers, or upon a determination that the contract providers are unable or unwilling to provide such services.

(3) The state department shall establish procedures requiring the provider to provide for proof of indigency to be submitted by the person seeking assistance, but the provider shall be responsible for the determination of eligibility.

(4) The state department shall establish procedures so that the providers of medical services rendered to the medically indigent cover geographic regions of the state.

(5) (a) The responsibilities of providers who provide medical care through the program for the medically indigent are as follows:

(I) Denver health and hospitals, including associated physicians, shall, up to its physical, staff, and financial capabilities as provided for under this program, be the primary providers of medical services to the medically indigent for the city and county of Denver.

(II) (A) University hospital and the physicians and other faculty members of the health sciences center shall, up to their physical, staff, and financial capabilities as provided for under this program, be the primary provider of medical services to the medically indigent for the Denver primary metropolitan statistical area.

(B) University hospital and the physicians and other faculty members of the health sciences center shall be the primary provider of such complex care as is not available or is not contracted for in the remaining areas of the state up to their physical, staff, and financial capabilities as provided for under this program.

~~(C) (Deleted by amendment, L. 2003, p. 875, § 3, effective April 7, 2003.)~~

(b) Any two or more providers awarded contracts may, with the approval of the state department, redistribute their respective populations and associated funds.

(c) Every provider who provides medical care through the program for the medically indigent shall comply with all procedures established by the state department.

~~(5.5) (Deleted by amendment, L. 2003, p. 875, § 3, effective April 7, 2003.)~~

(6) ~~(a)~~ The state department shall establish procedures that allocate funds to providers based on the anticipated utilization of services.

~~(b) (Deleted by amendment, L. 2003, p. 875, § 3, effective April 7, 2003.)~~

~~(7) (Deleted by amendment, L. 2003, p. 875, § 3, effective April 7, 2003.)~~

~~(8)~~ (7) A provider receiving reimbursement pursuant to this section shall transfer a medically indigent patient to another provider only with the prior agreement of the provider.

~~(9)~~ (8) (a) Every provider receiving reimbursement pursuant to this section shall prioritize for each fiscal year the medical services which it will be able to render, within the limits of the funds which will be made available by the state department.

(b) Such medical services shall be prioritized in the following order:

(I) Emergency care for the full year;

(II) Any additional medical care for those conditions the state department determines to be the most serious threat to the health of medically indigent persons;

(III) Any other additional medical care.

~~(10)~~ (9) A provider receiving reimbursement pursuant to this section shall not be

liable in civil damages for refusing to admit for treatment or for refusing to treat any medically indigent person for a condition which the state department or the provider has determined to be outside of the scope of the program.

~~(11) and (12) (Deleted by amendment, L. 2003, p. 875, § 3, effective April 7, 2003.)~~

~~(13)~~ (10) (a) A medically indigent person who wishes to be determined eligible for assistance under this part 1 shall comply with the eligibility requirements set by the state department.

(b) A medically indigent person requesting assistance under this ~~article~~ PART 1 specifically authorizes the state department or provider to:

(I) Use any information required by the eligibility requirements set by the state department for the purpose of verifying eligibility; and

(II) Obtain records pertaining to eligibility from a financial institution, as defined in section 15-15-201 (4), C.R.S., or from any insurance company.

(c) A medically indigent person requesting assistance under this ~~article~~ PART 1 shall be provided language clearly explaining the provisions of this subsection ~~(13)~~ (10).

~~(14)~~ (11) With the approval of the state department, any provider awarded a contract may enter into subcontracts or other agreements for services related to the program.

~~(15) (Deleted by amendment, L. 2003, p. 875, § 3, effective April 7, 2003.)~~

~~(16)~~ (12) Providers awarded contracts shall not be paid from funds made available for this program up to the extent, if any, of their annual financial obligation under the Hill-Burton act.

~~(17)~~ (13) When adopting or modifying procedures under this ~~article~~ PART 1, the state department shall notify each provider, who is contracted to provide medical care through the program for the medically indigent, at least thirty days prior to implementation of a new procedure. The state department shall hold a meeting for all providers at least thirty days prior to the implementation of a new procedure.

~~(18)~~ (14) The state department shall require any hospital provider who may receive payment under the program to annually submit data relating to the hospital's number of medicaid-eligible in-patient days and the hospital's total in-patient days in a form specified by the state department. The hospital provider shall verify the data to the state department through the program audit procedures required by the state department. The state department shall include this information by hospital in the department's annual budget request to the joint budget committee of the general assembly and in the report required by section ~~26-15-105~~ 25.5-3-107.

~~(19)~~ (15) To qualify for the program's payment formula disproportionate share hospital factor, as described in rule by the state board consistent with the provisions

of this part 1, a hospital provider's percent of medicaid-eligible in-patient days relative to total in-patient days shall be equal to or exceed one standard deviation above the mean.

25.5-3-109. [Formerly 26-15-110] Appropriations.

~~(1) (Deleted by amendment, L. 93, p. 1133, § 59, effective July 1, 1994.)~~

~~(2)~~ The general assembly shall make annual appropriations to the state department to accomplish the purposes of this part 1.

25.5-3-110. [Formerly 26-15-111] Effect of part 1. This part 1 shall not affect the department of human services' responsibilities for the provision of mental health care in accordance with part 2 of article 1 of title 27, C.R.S., and this part 1 shall not affect any provisions of article 22 of title 23, C.R.S., or any other provisions of law relating to the university of Colorado psychiatric hospital.

25.5-3-111. [Formerly 26-15-112] Penalties. Any person who represents that any medical service is reimbursable or subject to payment under this part 1 when he or she knows that it is not and any person who represents that he or she is eligible for assistance under this part 1 when he or she knows that he or she is not commits a class 2 misdemeanor and shall be punished as provided in section 18-1.3-501, C.R.S.

PART 2
COMPREHENSIVE PRIMARY AND
PREVENTIVE CARE GRANT PROGRAM

25.5-3-201. [Formerly 26-4-1001] Short title. This part ~~10~~ 2 shall be known and may be cited as the "Comprehensive Primary and Preventive Care Grant Program Act".

25.5-3-202. [Formerly 26-4-1002] Legislative declaration. (1) The general assembly hereby finds that preventive and primary care are two of the most cost-effective means of keeping people healthy. Unfortunately, many of the estimated five hundred seventy thousand Coloradans without health insurance coverage cannot afford routine preventive or primary health care. Instead, they wait until they are critically ill and then seek expensive, emergency care.

(2) It is the intent of the general assembly to establish a comprehensive primary and preventive care grant program and to fund the program with tobacco litigation settlement moneys. The purpose of the program is to expand prevention and primary care services to Colorado's low-income, uninsured populations.

(3) It is the intent of the general assembly that this grant program provide primary and preventive health care services to both adults and children. However, it is not the intent of the general assembly that this grant program supplant or expand the children's basic health plan, the state medical assistance program, or the Colorado indigent care program. Therefore, the general assembly finds it necessary to allow agencies who serve low-income, uninsured adults and children whose yearly family income is below two hundred percent of the federal poverty level to apply for grants

under this program and provide services to this needy population.

25.5-3-203. [Formerly 26-4-1003] Definitions. As used in this part ~~10~~ 2, unless the context otherwise requires:

(1) "Comprehensive primary care" means the basic, entry-level health care provided by health care practitioners or non-physician health care practitioners that is generally provided in an outpatient setting. "Comprehensive primary care", at a minimum, includes providing or arranging for the provision of the following services on a year-round basis: Primary health care; maternity care, including prenatal care; preventive, developmental, and diagnostic services for infants and children; adult preventive services, diagnostic laboratory and radiology services; emergency care for minor trauma; pharmaceutical services; and coordination and follow-up for hospital care. "Comprehensive primary care" may also include optional services based on a patient's needs. For the purposes of this subsection (1) and subsection (5) of this section, "arranging for the provision" means demonstrating established referral relationships with health care providers for any of the comprehensive primary care services not directly provided by an entity. An entity in a rural area may be exempt from this requirement if it can demonstrate that there are no providers in the community to provide one or more of the comprehensive primary care services.

(2) "Master settlement agreement" means the master settlement agreement, the smokeless tobacco master settlement agreement, and the consent decree approved and entered by the court in the case denominated *State of Colorado, ex rel. Gale A. Norton, Attorney General v. R.J. Reynolds Tobacco Co.; American Tobacco Co., Inc.; Brown & Williamson Tobacco Corp.; Liggett & Myers, Inc.; Lorillard Tobacco Co., Inc.; Philip Morris, Inc.; United States Tobacco Co.; B.A.T. Industries, P.L.C.; The Council For Tobacco Research--U.S.A., Inc.; and Tobacco Institute, Inc.*, Case No. 97 CV 3432, in the district court for the city and county of Denver.

(3) "Medically underserved area or population" means an area designated by the secretary of the United States department of health and human services, OR ANY SUCCESSOR AGENCY, as an area with a shortage of health care professionals or health services or a population or group designated by the secretary as having a shortage of such services.

(4) "Program" means the comprehensive primary and preventive care grant program established in this part ~~10~~ 2.

(5) "Qualified provider" means an entity that provides comprehensive primary care services and that:

(a) Accepts all patients regardless of their ability to pay and uses a sliding fee schedule for payments or that provides comprehensive primary care services free of charge;

(b) Serves a designated medically underserved area or population, as provided in section 330(b) of the federal "Public Health Service Act", 42 U.S.C. sec. 254b, or demonstrates to the state department that the entity serves a population or area that

lacks adequate health care services for low-income, uninsured persons;

(c) Has a demonstrated track record of providing cost-effective care;

(d) Provides or arranges for the provision of comprehensive primary care services to persons of all ages; and

(e) Completes initial screening for eligibility for the state medical assistance program, the children's basic health plan, and any other relevant government health care program and referral to the appropriate agency for eligibility determination.

(6) "Service grant" means a grant by the state department to a qualified provider pursuant to this part ~~10~~ 2.

(7) "Uninsured or medically indigent patient" means a patient receiving services from a qualified provider:

(a) Whose yearly family income is below two hundred percent of the federal poverty level; and

(b) Who is not eligible for medicaid, medicare, or any other type of governmental reimbursement for health care costs; and

(c) Who is not receiving third-party payments.

25.5-3-204. [Formerly 26-4-1004] Comprehensive primary and preventive care grant program - creation. There is hereby created in the state department the comprehensive primary and preventive care grant program. The program shall make service grants to qualified providers for their use in providing primary and preventive care to uninsured or medically indigent patients in Colorado.

25.5-3-205. [Formerly 26-4-1005] Grant-making process. (1) Any qualified provider desiring to participate in the program shall make application for a service grant to the state department in a form specified by rule of the state department. The state department shall receive service grant applications from any qualified provider. All applications shall be submitted and reviewed in accordance with grant procedures, criteria, and standards adopted by rule of the state department through the ~~medical services~~ STATE board.

(2) Service grants awarded to qualified providers shall be used by such providers only to:

(a) Increase access to comprehensive primary care services for uninsured or medically indigent patients who are served by such providers;

(b) Create new services or augment existing services provided to uninsured or medically indigent patients; or

(c) Establish new sites that offer comprehensive primary care services in medically underserved areas of the state or to medically underserved populations.

(3) Service grants to qualified providers shall not be used:

(a) To supplant federal funds traditionally received by such qualified providers but shall be used to supplement such funds;

(b) For land or real estate investments;

(c) To finance or satisfy any existing debt; or

(d) Unless the qualified provider specifically complies with the definition of qualified provider contained in section ~~26-4-1003 (5)~~ 25.5-3-203 (5).

(4) The executive director shall appoint an advisory council to review and make recommendations to the state department on the protocols related to awarding grants to qualified providers and to provide feedback to the state department on the design and content of the application and the application and evaluation processes. The advisory council shall consist of the following members:

(a) One employee of the state department;

(b) One employee of the department of public health and environment;

(c) A representative of a qualified provider;

(d) Two consumers who currently receive health care services from a qualified provider;

(e) A health care provider who is not affiliated with a qualified provider or an agency of the state but who has training and expertise in providing comprehensive primary care services to medically underserved populations; and

(f) A representative of a nonprofit, community-based health care organization or business.

~~(4.2)~~ (5) All service grants shall be awarded within thirty days after approval by the state department.

~~(4.5)~~ (6) The state department shall consider geographic distribution of funds among urban and rural areas in the state when making funding decisions.

~~(5)~~ (7) The state department shall:

(a) Develop ~~regulations~~ RULES, procedures, and application forms to govern how service grants shall be awarded; and

(b) Develop an audit procedure to assure that service grant moneys are used to provide and expand coverage to uninsured and medically indigent patients.

25.5-3-206. [Formerly 26-4-1006] Reports. (1) On or before January 1, 2001, and on or before each January 1 thereafter, pursuant to section 25-1-108.5 (2), C.R.S., the state department shall submit a report to the state board of health and to

the department of public health and environment on the operation and the effectiveness of the program.

(2) Each qualified provider receiving a service grant shall report annually to the state department concerning the number of additional uninsured and medically indigent patients that are cared for and the types of services that are provided.

25.5-3-207. [Formerly 26-4-1007] Program funding - comprehensive primary and preventive care fund - creation. (1) Moneys for service grants and for the payment of program administrative costs incurred by the state department shall be payable from the comprehensive primary and preventive care fund, which fund is hereby created in the state treasury. The comprehensive primary and preventive care fund, referred to in this section as the "fund", shall consist of moneys appropriated thereto by the general assembly from moneys received pursuant to the master settlement agreement in the amount described in subsection (3) of this section. In addition, the state treasurer may credit to the fund any public or private gifts, grants, or donations received by the state department for implementation of the program. The fund shall be subject to annual appropriation by the general assembly to the state department. In addition, the state department may retain up to one percent of the amount annually appropriated from the fund for the actual costs incurred by the state department in implementing the provisions of this part ~~to~~ 2. Notwithstanding the provisions of section 24-36-114, C.R.S., all interest derived from the deposit and investment of moneys in the fund shall be credited to the fund. Any unencumbered moneys appropriated from moneys received pursuant to the master settlement agreement remaining in the fund at the end of any fiscal year shall be transferred to the tobacco litigation settlement trust fund created in section 24-22-115.5, C.R.S.

(2) It is the intent of the general assembly that general fund moneys not be appropriated for implementation of the program.

(3) ~~(a)~~ Pursuant to section 24-75-1104.5 (1) (b), C.R.S., beginning with the 2004-05 fiscal year, and for each fiscal year thereafter so long as the state receives moneys pursuant to the master settlement agreement, the general assembly shall appropriate to the fund three percent of the total amount of moneys received by the state pursuant to the master settlement agreement, not including attorney fees and costs, during the preceding fiscal year; except that the amount so appropriated to the fund shall not exceed five million dollars in any fiscal year. The general assembly shall appropriate the amount specified in this subsection (3) from moneys credited to the tobacco litigation settlement cash fund created in section 24-22-115, C.R.S.

~~(b) Repealed.~~

PART 3 PRIMARY CARE FUND

25.5-3-301. [Formerly 25.5-3-101] Definitions. As used in this ~~article~~ PART 3, unless the context otherwise requires:

(1) "Comprehensive primary care" shall have the same meaning as provided in section ~~26-4-1003 (1), C.R.S.~~ 25.5-3-203 (1).

(2) "Qualified provider" shall have the same meaning as provided in section ~~26-4-1003 (5), C.R.S.~~ 25.5-3-203 (5).

(3) "Uninsured or medically indigent patient" shall have the same meaning as provided in section ~~26-4-1003 (7), C.R.S.~~ 25.5-3-203 (7).

25.5-3-302. [Formerly 25.5-3-102] Annual allocation - primary care services - qualified provider. (1) The state department shall annually allocate the moneys appropriated by the general assembly to the primary care fund created in section 24-22-117, C.R.S., to all eligible qualified providers in the state who comply with the requirements of subsection (2) of this section. The state department shall allocate the moneys in amounts proportionate to the number of uninsured or medically indigent patients served by the qualified provider. For a qualified provider to be eligible for an allocation pursuant to this section, the qualified provider shall meet either of the following criteria:

(a) The qualified provider is a community health center, as defined in section 330 of the federal "Public Health Services Act", 42 U.S.C. sec. 254b; or

(b) At least fifty percent of the patients served by the qualified provider are uninsured or medically indigent patients, or patients who are enrolled in the medical assistance program, ~~article 4 of title 26, C.R.S.~~ ARTICLES 4, 5, AND 6 OF THIS TITLE, or the children's basic health plan, ~~article 19 of title 26, C.R.S.~~ ARTICLE 8 OF THIS TITLE, or any combination thereof.

(2) A qualified provider shall annually submit to the state department information sufficient to establish the provider's eligibility status. A qualified provider, except for a provider specified in paragraph (a) of subsection (1) of this section, shall provide an annual report that includes the total number of patients served, the number of uninsured or medically indigent patients served, and the number of patients served who are enrolled in the medical assistance program, ~~article 4 of title 26, C.R.S.~~ ARTICLES 4, 5, AND 6 OF THIS TITLE, or the children's basic health plan, ~~article 19 of title 26, C.R.S.~~ ARTICLE 8 OF THIS TITLE. A community health center specified in paragraph (a) of subsection (1) of this section shall annually provide to the state department the number of uninsured or medically indigent patients served. Each eligible qualified provider shall annually develop and submit to the state department documentation regarding the quality assurance program in place at the provider's facility to ensure that quality comprehensive primary care services are being provided. All qualified providers shall submit to the state department the information required under this section, as specified in rule by the state board. The data regarding the number of patients served shall be verified by an outside entity. For purposes of this ~~article~~ PART 3, the number of patients served shall be the number of unduplicated users of health care services and shall not be the number of visits by a patient.

(3) The state department shall make annual direct allocations of the total amount of money annually appropriated by the general assembly to the primary care fund pursuant to section 24-22-117, C.R.S., minus three percent for the administrative costs of the program, to all eligible qualified providers. An eligible qualified provider's allocation shall be based on the number of uninsured or medically indigent patients served by the provider in proportion to the total number of

uninsured or medically indigent patients served by all eligible qualified providers in the previous calendar year. The state department shall establish a schedule for allocating the moneys in the primary care fund for eligible qualified providers. The disbursement of moneys in the primary care fund to eligible qualified providers under this ~~article~~ PART 3 shall be exempt from the provisions of the "Procurement Code", article 101 to 112 of title 24, C.R.S.

(4) The state board shall adopt any rules necessary for the administration and implementation of this ~~article~~ PART 3.

25.5-3-303. [Formerly 25.5-3-103] Consultation. Not less frequently than annually, the state department shall consult with representatives of federally qualified health centers, school-based health centers, family residency directors, certified rural health clinics, other qualified providers, and consumer advocates regarding the implementation and administration of the allocation of moneys to qualified providers under this ~~article~~ PART 3.

SECTION 7. Title 25.5, Colorado Revised Statutes, is amended BY THE ADDITION OF THE FOLLOWING NEW ARTICLES, CONTAINING RELOCATED PROVISIONS, WITH AMENDMENTS, to read:

ARTICLE 4
Colorado Medical Assistance Act
General Medical Assistance

PART 1
GENERAL PROVISIONS

25.5-4-101. [Formerly 26-4-101] Short title. This article AND ARTICLES 5 AND 6 OF THIS TITLE shall be known and may be cited as the "Colorado Medical Assistance Act".

25.5-4-102. [Formerly 26-4-102] Legislative declaration. It is the purpose of ~~this article~~ THE "COLORADO MEDICAL ASSISTANCE ACT" to promote the public health and welfare of the people of Colorado by providing, in cooperation with the federal government, medical and remedial care and services for individuals and families whose income and resources are insufficient to meet the costs of such necessary services and to assist such individuals and families to attain or retain their capabilities for independence and self-care, as contemplated by the provisions of Title XIX of the social security act. The state of Colorado and its various departments, agencies, and political subdivisions are authorized to promote and achieve these ends by any appropriate lawful means, through cooperation with and the utilization of available resources of the federal government and private individuals and organizations.

25.5-4-103. [Formerly 26-4-103] Definitions. As used in this article AND ARTICLES 5 AND 6 OF THIS TITLE, unless the context otherwise requires:

(1) "1931 medicaid recipient" means any person who is eligible for medicaid as provided in section ~~26-4-201 (1) (a), 26-4-301 (1) (a), or 26-4-301 (1) (c)~~ 25.5-5-101 (1) (a), 25.5-5-201 (1) (a), OR 25.5-5-201 (1) (h) and refers to section

1931 of Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396u-1.

~~(1.5)~~ (2) "Applicant" means any person who has applied for benefits under this article AND ARTICLES 5 AND 6 OF THIS TITLE.

~~(2)~~ (3) "Case management services" means services provided by community centered boards as defined by section 27-10.5-102 (3), C.R.S., and community mental health centers and community mental health clinics, as defined by section 27-1-201, C.R.S., to assist developmentally disabled persons as defined by section 27-10.5-102 (11), C.R.S., and mentally ill persons as defined by section 27-10-102 (7), C.R.S., by case management agencies, as defined in section ~~26-4-603 (5)~~ 25.5-6-303 (5), providing services, as defined in sections ~~26-4-507 (2) (b) and 26-4-603 (6)~~ 25.5-6-104 (2) (b) AND 25.5-6-303 (6), to elderly, blind, and disabled persons and long-term care clients, in gaining access to needed medical, social, educational, and other services.

~~(3)~~ (4) "Categorically needy" means those persons who are eligible for medical assistance under this article AND ARTICLES 5 AND 6 OF THIS TITLE due to their eligibility for one or more of the federal categories of public assistance. A person may be categorically needy and eligible for medical assistance under mandatory provisions as provided under section ~~26-4-201~~ 25.5-5-101 or may be categorically needy under optional provisions as provided under section ~~26-4-301~~ 25.5-5-201.

~~(4)~~ (5) "Clinic services" means those services as defined in section ~~26-4-513~~ 25.5-5-301.

~~(5)~~ (6) "Essential person" means a person who meets the requirements of section 26-2-103 (5), C.R.S.

~~(6)~~ (7) "Home health services" is synonymous with "home health care" and includes the following services provided to an eligible person in his place of residence, through a certified home health agency, pursuant to a home health plan of care:

(a) Nursing services;

(b) Home health aide services;

(c) Provision of medical supplies, equipment, and appliances suitable for use in the home;

(d) Physical therapy, occupational therapy, or speech and hearing therapy.

~~(7)~~ (8) "Hospice care" means services provided by a public agency or private organization, or any subdivision thereof, which entity shall be known as a hospice and shall be primarily engaged in providing care to an individual for whom a certified medical prognosis has been made indicating a life expectancy of six months or less and who has elected to receive such care in lieu of other medical benefits available under this article AND ARTICLES 5 AND 6 OF THIS TITLE.

~~(8)~~ (9) "Intermediate nursing facility for the mentally retarded" means a

tax-supported, state-administered intermediate nursing facility, or a distinct part of such facility, which meets the state nursing home licensing standards set forth in section 25-1.5-103 (1) (a) (I), C.R.S., and the requirements in 42 U.S.C. sec. 1396d and which:

(a) Is maintained primarily to provide health-related care on a regular basis for the mentally retarded or for persons with developmental disabilities, as defined in section 27-10.5-102 (11), C.R.S., who do not require the degree of care and treatment which a hospital or skilled nursing facility can provide but who, because of their mental or physical condition, require care and services above the level of room and board, which can be made available only through institutional facilities; and

(b) May provide care which includes but is not limited to moderate assistance or therapy functions; occasional direction, supervision, or therapy; moderate assistance or therapy for loss of mobility; routine, nonskilled nursing services; and monitoring of the drug regimen.

~~(8.5)~~ (10) "Legal immigrant" means an individual who is not a citizen or national of the United States and who was lawfully admitted to the United States by the immigration and naturalization service as an actual or prospective permanent resident or whose extended physical presence in the United States is known to and allowed by the immigration and naturalization service.

~~(9)~~ (11) "Liable" or "liability" means the legal liability of a third party, either by reason of judgment, settlement, compromise, or contract, as the result of negligent acts or other wrongful acts or otherwise for all or any part of the medical cost of an injury, a disease, or the disability of an applicant for or recipient of medical assistance.

~~(9.5)~~ (12) "Managed care system" means a system for providing health care services which integrates both the delivery and the financing of health care services in an attempt to provide access to medical services while containing the cost and use of medical care.

~~(10)~~ (13) "Medical assistance" means payment on behalf of recipients ELIGIBLE FOR AND ENROLLED IN THE PROGRAM ESTABLISHED IN ARTICLES 4, 5, AND 6 OF THIS TITLE, WHICH IS FUNDED THROUGH TITLE XIX OF THE FEDERAL "SOCIAL SECURITY ACT", 42 U.S.C. SECTION 1396u-1, to enrolled providers under the state medical assistance program of medical care, services, goods, and devices rendered or provided to recipients under this article AND ARTICLES 5 AND 6 OF THIS TITLE, and other related payments, pursuant to this article AND ARTICLES 5 AND 6 OF THIS TITLE and the rules and regulations of the state department.

~~(11)~~ (14) "Nursing facility" means a facility, or a distinct part of a facility, which meets the state nursing home licensing standards in section 25-1.5-103 (1) (a) (I), C.R.S., is maintained primarily for the care and treatment of inpatients under the direction of a physician, and meets the requirements in 42 U.S.C. sec. 1396r for certification as a qualified provider of nursing facility services. The patients in such a facility require supportive, therapeutic, or compensating services and the availability of a licensed nurse for observation or treatment on a twenty-four-hour

basis. Nursing care may include but is not limited to terminal care; extensive assistance or therapy in the activities of daily living; continual direction, supervision, or therapy; extensive assistance or therapy for loss of mobility; nursing assessment and services which involve assessment of the total needs of the patient, planning of patient care, and observing, monitoring, and recording the patient's response to treatment; and monitoring, observing, and evaluating the drug regimen. "Nursing facility" includes private, nonprofit, or proprietary intermediate nursing facilities for the mentally retarded or developmentally disabled.

~~(11.5)~~ (15) "Overpayment" means the amount paid by an agency administering the medical assistance program to an enrolled provider under the state medical assistance program participating in the program, which amount is in excess of the amount that is allowable for services furnished and which is required by Title XIX of the social security act to be refunded to the appropriate medicaid agencies.

~~(12)~~ (16) "Patient personal needs trust fund" means any fund or account established by the nursing care facility or intermediate care facility or its agents, employees, or designees to manage the personal needs funds of the facility's patients.

~~(13)~~ (17) "Personal needs funds" means moneys received by any person admitted to a nursing care facility or intermediate care facility, which moneys are received by said person to purchase necessary clothing, incidentals, or other personal needs items which are not reimbursed by any federal or state program, or items of value, which moneys or items of value are in any way surrendered to the management or control of said facility, its agents, employees, or designees.

~~(13.3)~~ (18) "Pilot program", as used in section ~~26-4-414.7~~ 25.5-5-319, means the family planning pilot program established in section ~~26-4-414.7~~ 25.5-5-319, which is carried out by all medicaid providers who provide family planning services and which shall be repealed, effective July 1 five years after the issuance of the federal waiver or July 1 in the year in which the waiver is terminated, whichever occurs first.

~~(13.5)~~ (19)(a) "Provider" means any person, public or private institution, agency, or business concern providing medical care, services, or goods authorized under this article AND ARTICLES 5 AND 6 OF THIS TITLE and holding, where applicable, a current valid license or certificate to provide such services or to dispense such goods and enrolled under the state medical assistance program. These services must be provided and goods must be dispensed only if performed, referred, or ordered by a doctor of medicine or a doctor of osteopathy. Services of dentists, podiatrists, and optometrists or services provided by a school district under section ~~26-4-531~~ 25.5-5-318 need not be referred or ordered by a doctor of medicine or a doctor of osteopathy.

(b) "Provider" includes a laboratory certified under the federal "Clinical Laboratories Improvement Act of 1967", as amended, 42 U.S.C. sec. 263a to perform high complexity testing.

~~(13.7)~~ (20) "Qualified alien" shall have the meaning ascribed to that term in section 431 (b) of the federal "Personal Responsibility and Work Opportunity

Reconciliation Act of 1996", Public Law 104-193, as amended.

~~(14)~~ (21) "Recipient" means any person who has been determined eligible to receive benefits under this article AND ARTICLES 5 AND 6 OF THIS TITLE, whose need for medical care has been professionally established, and for whose care less than full payment is available through the legal obligation of a contractor, public or private, to pay for or provide such care.

~~(15)~~ (22) "Recovery" or "amount recovered" means the amount payable to the applicant or recipient or his heirs, assigns, or legal representatives as the result of any liability of a third party.

~~(16)~~ (23) "Rehabilitative services" means any medical or remedial services recommended by a physician which may reduce physical or mental disability and which may improve functional level.

~~(17)~~ (24) "Resident" means any individual who is living, other than temporarily, within the state. "Resident" includes any unemancipated child whose parent, or other person entitled to custody, lives within the state. The state ~~department~~ BOARD shall adopt rules ~~and regulations~~ for making this determination. Temporary absences from the state shall not cause an individual to lose his status as a resident of this state.

~~(18)~~ (25) "Social security act" means the federal "Social Security Act" and amendments thereto.

~~(19)~~ (26) "Third party" means an individual, institution, corporation, or public or private agency which is or may be liable to pay all or any part of the medical cost of an injury, a disease, or the disability of an applicant for or recipient of medical assistance.

~~(20)~~ (27) "Title XIX" means Title XIX of the social security act, as amended, administered by the federal department of health and human services, OR ANY SUCCESSOR AGENCY, and includes amendments thereto and other federal social security laws replacing said title, in whole or in part.

~~(21) (Deleted by amendment, L. 95, p. 905, § 5, effective May 25, 1995.)~~

~~(22)~~ (28) "Transitional medicaid" means the medical assistance provided to recipients eligible pursuant to section ~~26-4-201 (1) (b)~~ 25.5-5-101 (1) (b).

25.5-4-104. [Formerly 26-4-104] Program of medical assistance - single state agency. (1) The state department, by rules, ~~and regulations~~, shall establish a program of medical assistance to provide necessary medical care for the categorically needy. The state department is hereby designated as the single state agency to administer such program in accordance with Title XIX and this article AND ARTICLES 5 AND 6 OF THIS TITLE. Such program shall not be required to furnish recipients under sixty-five years of age the benefits that are provided to recipients sixty-five years of age and over under Title XVIII of the social security act; but said program shall otherwise be uniform to the extent required by Title XIX of the social security act.

(2) The state department may review any decision of a county department and may consider any application upon which a decision has not been made by the county department within a reasonable time to determine the propriety of the action or failure to take timely action on an application for medical assistance. The state department shall make such additional investigation as it deems necessary and shall, after giving the county department an opportunity to rebut any findings or conclusions of the state department that the action or delay in taking action was a violation of or contrary to state department rules, make such decision as to the granting of medical benefits and the amount thereof as in its opinion is justifiable pursuant to the provisions of this article AND ARTICLES 5 AND 6 OF THIS TITLE and the rules of the state department. Applicants or recipients affected by such decisions of the state department, upon request, shall be given reasonable notice and opportunity for a fair hearing by the state department.

25.5-4-105. [Formerly 26-4-105] Federal requirements under Title XIX. Nothing in this article OR ARTICLES 5 AND 6 OF THIS TITLE shall prevent the state department from complying with federal requirements for a program of medical assistance in order for the state of Colorado to qualify for federal funds under Title XIX of the social security act and to maintain a program within the limits of available appropriations.

25.5-4-106. [Formerly 26-4-110] Cooperation with federal government - grants-in-aid - cooperation with the department of human services in delivery of services. (1) The state department ~~of health care policy and financing~~ shall be the sole state agency for administering the state plans for ~~medical assistance including but not limited to the home care allowance program, the adult foster care program, and health and medical assistance pursuant to this article~~ TITLE, and any other state plan relating to medical assistance that requires state action which is not specifically the responsibility of some other state department, division, section, board, commission, or committee under the provisions of federal or state law.

(2) (a) The state department ~~of health care policy and financing~~ may accept on behalf of the state of Colorado the provisions and benefits of acts of congress designed to provide funds or other property for particular medical assistance within the state, which funds or other property are designated for such purposes within the function of the state department, and may accept on behalf of the state any offers which have been or may from time to time be made of funds or other property by any persons, agencies, or entities for particular medical assistance activities within the state, which funds or other property are designated for such purposes within the function of the state department; but, unless otherwise expressly provided by law, such acceptance shall not be manifested unless and until the state department has recommended such acceptance to and received the written approval of the governor and the attorney general. Such approval shall authorize the acceptance of the funds or property in accordance with the restrictions and conditions for the purpose for which funds or property are intended.

(b) The state treasurer is designated as ex officio custodian of all medical assistance funds received by the state from the federal government and from any other source, if the approval provided for in paragraph (a) of this subsection (2) has been obtained.

(c) The state treasurer shall hold each such fund separate and distinct from state funds and is authorized to make disbursements from such funds for the designated purpose or for administrative costs, which may be provided in such grants upon warrants issued by the state controller upon the voucher of the state department.

(3) The state department shall cooperate with the federal department of health and human services and other federal agencies in any reasonable manner, in conformity with the laws of this state, which may be necessary to qualify for federal ~~aid~~ FINANCIAL PARTICIPATION, including the preparation of state plans, the making of reports in such form and containing such information as any federal agency may from time to time require, and the compliance with such provisions as the federal government may from time to time find necessary to assure the correctness and verification of the reports.

(4) The rules ~~and regulations~~ of the state department may include provisions to accommodate requirements of contracts entered into between the state department and the federal department of health and human services, OR ANY SUCCESSOR AGENCY, for studies of guaranteed annual income or other forms of income maintenance research projects; and for such purpose, the requirements of this title as to eligibility for medical assistance shall not apply for the term of and in accordance with the contract for such purpose.

(5) The ~~STATE department of health care policy and financing and the department of human services shall cooperate in~~ IS RESPONSIBLE FOR administering the delivery of medical assistance by county departments of social services or any other public or private entities participating in the delivery of medical assistance pursuant to this article AND ARTICLES 5 AND 6 OF THIS TITLE.

PART 2 ADMINISTRATION

25.5-4-201. [Formerly 26-4-110.7] Cash system of accounting - financial administration of medical services premiums - medical programs administered by department of human services. (1) The state department shall utilize the cash system of accounting, as enunciated by the governmental accounting standards board, regardless of the source of revenues involved, for all activities of the state department relating to the financial administration of:

(a) Medical services premiums; and

(b) Medical programs under this article administered by the department of human services, except for expenditures for costs incurred in the administration of such programs.

25.5-4-202. [Formerly 26-4-107] Comprehensive plan for other services and benefits. In accordance with federal requirements pertaining to the development of a broad-based medical care program for low-income families, the state department shall prepare a comprehensive medical plan for consideration by the house and senate committees on ~~health, environment, welfare, and institutions~~ HEALTH AND HUMAN SERVICES, OR ANY SUCCESSOR COMMITTEES. The comprehensive plan shall include alternate means of expanding the medical care

benefits and coverage provided in this article AND ARTICLES 5 AND 6 OF THIS TITLE. The comprehensive plan shall be reevaluated annually and shall be based upon a documented review of medical needs of low-income families in Colorado, a detailed analysis of priorities of service, coverage, and program costs, and an evaluation of progress. The medical advisory council appointed pursuant to this article shall assist the state department in the preparation of the comprehensive plan.

25.5-4-203. [Formerly 26-4-108] Advisory council established. ~~(1)~~ There is hereby created a state medical assistance and services advisory council, referred to in this article as the "advisory council", consisting of sixteen members. Ex officio members of the advisory council shall be the executive directors of the state department and the department of health or their successors in function. The remaining members of the advisory council shall be appointed by the governor and shall be chosen by him to represent the various areas of medical services and the public. Specifically included shall be two members who are doctors of medicine licensed in this state, one doctor of osteopathy licensed in this state, one dentist licensed in this state, one optometrist licensed in this state, one owner or operator of a licensed nursing facility in this state, one member who shall represent licensed hospitals in this state, one pharmacist licensed in this state, one professional nurse licensed in this state, one member who has provided home health care services for three years, and three members who are not directly associated with the areas of medical services to represent the public. The remaining member may represent any other area of medical services not specifically enumerated but shall not be limited thereto. Members shall serve at the pleasure of the governor and shall receive no compensation but shall be reimbursed for their actual and necessary expenses. The advisory council shall advise the state department on the provision of health and medical care services to recipients.

~~(2) Repealed.~~

25.5-4-204. [Formerly 26-4-403.7] Automated medical assistance administration. (1) The general assembly hereby finds and declares that the agency responsible for the administration of the state's medical assistance program would be more effective in its ability to streamline administrative functions of program administrators and providers under the program through the implementation of an automated system that will provide for the following:

- (a) Electronic claim submittals;
- (b) On-line eligibility determinations;
- (c) Electronic remittance statements;
- (d) Electronic fund transfers; and
- (e) Automation of other administrative functions associated with the medical assistance program.

(2) Therefore, the general assembly declares that it is appropriate to enact legislation, as set forth in subsection (3) of this section, that authorizes the state department to develop and implement an automated system for processing claims

and payments under the medical assistance program, as well as for other administrative functions associated with the program.

(3) The executive director of the state department shall develop and implement an automated system through which medical assistance claims and payments and eligibility determinations or other related transactions may be processed. The system shall provide for the use of automated electronic technologies. The automated system may be implemented in phases if deemed necessary by the executive director. The automated system shall be implemented only after the executive director determines that:

(a) Technology is available and proven to perform satisfactorily in a production environment;

(b) Adequate financing is available to facilitate the implementation and maintenance of the system. Financing may include, but is not limited to, federal funds, appropriations from the general fund, provider transaction fees, or any other financing mechanisms which the state department may impose, and grants or contributions from public or private entities.

(c) The system has been successfully installed and fully tested; and

(d) Adequate provider training has been provided for an orderly implementation.

~~(4) On or before July 1, 1993, and prior to the implementation of the automated system, the executive director of the state department, with input from the pharmacy advisory committee, created in section 26-4-408, shall submit to the state medical assistance and services advisory council created in section 26-4-108, the medical services board, and the joint budget committee of the general assembly an implementation plan, addressing the items to be determined in subsection (3) of this section.~~

25.5-4-205. [Formerly 26-4-106] Application - verification of eligibility - repeal. (1) (a) Determination of eligibility for medical benefits shall be made by the county department in which the applicant resides, except as otherwise specified in this section. Local social security offices also determine eligibility for medicaid benefits at the same time they determine eligibility for supplemental security income. The state department may accept medical assistance applications and determine medical assistance eligibility and may designate the private service contractor that administers the children's basic health plan, Denver health and hospitals, a hospital that is designated as a regional pediatric trauma center, as defined in section 25-3.5-703 (4) (f), C.R.S., and other medical assistance sites determined necessary by the state department to accept medical assistance applications, to determine medical assistance eligibility, and to determine presumptive eligibility. When the state department determines that it is necessary to designate an additional medical assistance site, the state department shall notify the county in which the medical assistance site is located that an additional medical assistance site has been designated. Any person who is determined to be eligible pursuant to the requirements of this article AND ARTICLES 5 AND 6 OF THIS TITLE shall be eligible for benefits until such person is determined to be ineligible. Upon determination that any person is ineligible for medical benefits, the county

department, the state department, or other entity designated by the state department shall notify the applicant in writing of its decision and the reason therefor. Separate determination of eligibility and formal application for benefits under this article AND ARTICLES 5 AND 6 OF THIS TITLE for persons eligible as provided in sections ~~26-4-201 and 26-4-301~~ 25.5-5-101 AND 25.5-5-201 shall be made in accordance with the rules of the state department.

~~(b)(I) Eligibility for medical benefits may be made by state department eligibility technicians located at the private service contractor that administers the children's basic health plan for the sole purpose of determining the medicaid eligibility of persons applying for the children's basic health plan.~~

~~(H) and (H) Repealed.~~

~~(c)~~ (b) The state department shall develop training safeguards to prevent actions taken by staff of medical assistance sites from affecting food and cash assistance eligibility.

(2) (a) Any married couple, at the beginning of a continuous period of institutionalization of one spouse, may request the county department to assess and document the total value of the resources of the couple, if the couple supplies to the county department the necessary information and documentation which is needed to make such an assessment.

(b) Any assessment prepared by the county department and provided to a couple shall contain a procedure for appealing any determinations which have been made.

(c) If a request for assessment and documentation is not part of an application for medical assistance, the county department may establish a fee not exceeding the reasonable expenses of the county department of providing and documenting such assessment.

(3) The state department shall promulgate rules to simplify the processing of applications in order that medical benefits are furnished to recipients as soon as possible, including rules that provide for initial processing of applications and determination of eligibility for medical assistance only at locations other than the county departments, at locations used for processing applications for the Colorado works program, or at the location used by the private service contractor that administers the children's basic health plan for determining eligibility of children for such plan. Said rules may make provision for the payment of medical benefits for a period not to exceed three months prior to the date of application in cases where the applicant did not make application prior to his or her need for said medical benefits. Adequate safeguards shall be established by the state department to ensure that only eligible persons receive benefits under this article AND ARTICLES 5 AND 6 OF THIS TITLE. In addition, an applicant who is eighteen years of age or older shall be required to supply a form of personal photographic identification either by providing a valid Colorado driver's license or a valid identification card issued by the department of revenue pursuant to section 42-2-302, C.R.S. The state department may adopt rules that exempt applicants from the requirement of supplying a form of personal photographic identification if such requirement causes an unreasonable hardship or if such requirement is in conflict with federal law. The

state department shall also adopt rules that allow for assistance to be provided on an emergency basis until the applicant is able to obtain or qualify for a driver's license or identification card; however, a county department or an entity designated by the state department pursuant to subsection (1) of this section is not required to recover emergency assistance from an applicant who fails, upon recertification, to meet the photographic identification requirement.

(4) By signing an application for medical assistance, a person assigns to the state department, by operation of law, all rights the applicant may have to medical support or payments for medical expenses from any other person on his own behalf or on behalf of any other member of his family for whom application is made. For purposes of this subsection (4), an assignment takes effect upon the determination that the applicant is eligible for medical assistance and up to three months prior to the date of application if the applicant meets the requirements of subsection (3) of this section and shall remain in effect so long as an individual is eligible for and receives medical assistance benefits. The application shall contain a statement explaining this assignment.

(5) (a) The state department shall not pursue recovery from a county for the cost of medical services provided to a person who has been incorrectly determined eligible for medical assistance by that county or any other entity.

(b) This subsection (5) is repealed, effective July 1, 2008.

~~(6) On or before December 1, 2005, the state department shall report to the health and human services committees of the house of representatives and the senate the progress of the private service contractor that administers the children's basic health plan, Denver health and hospitals, and any other medical assistance site in accepting medical assistance applications, determining medical assistance eligibility, and determining presumptive eligibility pursuant to subsection (1) of this section.~~

25.5-4-206. [Formerly 26-4-411] Reimbursement to counties - costs of administration. The state department shall reimburse the county departments for costs of administration incurred by the counties under this article AND ARTICLES 5 AND 6 OF THIS TITLE in accordance with the provisions of section 26-1-122 (5), C.R.S.

25.5-4-207. [Formerly 26-4-402] Appeals. (1) (a) ~~(b)~~ If an application for medical benefits is not acted upon by the county department within a reasonable time after filing of the same, or if an application is denied in whole or in part, or if medical benefits are suspended, terminated, or modified, the applicant or recipient, as the case may be, may appeal to the state department in the manner and form prescribed by the rules of the state department. Every county department or service delivery agency shall adopt procedures for the resolution of disputes arising between the county department or the service delivery agency and any applicant for or recipient of medical assistance prior to appeal to the state department. Such procedures are referred to in this section as the "dispute resolution process". Two or more counties may jointly establish the dispute resolution process. The dispute resolution process shall be consistent with rules promulgated by the state board pursuant to article 4 of title 24, C.R.S. The dispute resolution process shall include an opportunity for all clients to have a county conference, upon the client's request,

and such requirement may be met through a telephonic conference upon the agreement of the client and the county department. The dispute resolution process need not conform to the requirements of section 24-4-105, C.R.S., as long as the rules adopted by the state board include provisions specifically setting forth expeditious time frames, notice, and an opportunity to be heard and to present information. If the dispute is not resolved, the applicant or recipient may appeal to the state department in the manner and form prescribed by the rules of the state department. County notices to applicants or recipients shall inform them of the basis for the county's decision or action and shall inform them of their rights to a county conference under the dispute resolution process and of their rights to state level appeal and the process of making such appeal. The state board shall adopt rules setting forth what other issues, if any, may be appealed by an applicant or recipient to the state department. A hearing need not be granted when either state or federal law requires or results in a reduction or deletion of a medical benefit unless the applicant or recipient is arguing that his or her case does not fit within the parameters set forth by the change in the law. In notifying the applicant or recipient that an appeal is being denied because of a change in state or federal law, the state's notice shall inform the applicant or recipient that further appeal should be directed to the appropriate state or federal court.

~~(H)~~ (b) Upon receipt of an appeal, the state department shall give the appellant at least ten days' notice and an opportunity for a fair hearing in accordance with the rules of the state department. Any such fair hearing shall comply with section 24-4-105, C.R.S., and the state department's administrative law judge shall preside.

~~(HH)~~ (c) The appellant shall have an opportunity to examine all applications and pertinent records concerning said appellant that constitute a basis for the denial, suspension, termination, or modification of medical benefits.

~~(b) (Deleted by amendment, L. 97, p. 1319, § 2, effective July 1, 1997.)~~

(2) All decisions of the state department shall be binding upon the county department involved and shall be complied with by such county department.

25.5-4-208. [Formerly 26-4-106.5] County duties - transitional medicaid. County departments shall assist families in completing the reporting requirements for transitional medicaid. This shall include informing 1931 medicaid recipients, as defined in section ~~26-4-103 (1)~~ 25.5-4-103 (1), of the transitional medicaid eligibility requirements and the required reporting calendar.

25.5-4-209. [Formerly 26-4-518] Payments by third parties - copayments by recipients - review - appeal. (1) (a) Any recipient receiving benefits under this article OR ARTICLE 5 OR 6 OF THIS TITLE who receives any supplemental income, available for medical purposes under rules ~~and regulations~~ of the state department, or who receives proceeds from sickness, accident, health, or casualty insurance shall apply the supplemental income to the cost of the benefits rendered, and the rules ~~and regulations~~ may require reports from providers of other payments received by them from or on behalf of recipients.

(b) Subject to any limitations imposed by Title XIX, a recipient shall be required to pay at the time of service a portion of the cost of any medical benefit rendered to

~~him~~ THE RECIPIENT or to ~~his~~ THE RECIPIENT'S dependents pursuant to this article OR ARTICLE 5 OR 6 OF THIS TITLE, as determined by rule ~~or regulation~~ of the state department.

(2) (a) Notwithstanding the provisions of section 26-1-114, C.R.S., the state department is authorized to share information with and require any insurer or nonprofit hospital and health service corporation to provide information concerning coverage of any recipient but only in the manner provided in this section.

(b) In order to determine if applicants for or recipients of medical assistance have coverages, the state department may provide to such insurer or nonprofit hospital and health service corporation a list of social security numbers identifying these applicants or recipients and may require them to provide a written computerized match disclosing any coverages for individuals adequately identified on such list. The requirement to run such computerized match shall apply only to information which is entered in the insurer's or nonprofit hospital and health service corporation's data processing system on the date the match is run and shall not require such insurer or corporation to change its data or make new entries for the purpose of comparing identifying information.

(c) The cost to such insurer or corporation of providing such computerized match shall be borne by the state department.

(d) No such insurer or corporation which provides data required by the state department, whether confidential or not, shall be held liable for the provision of such data to the state department or for any use made thereof.

(e) For the fiscal year beginning July 1, 1984, and thereafter, all funds expended by the state department to pay the cost of providing such computerized matches shall be subject to an annual appropriation by the general assembly.

(f) The state department may expend funds appropriated pursuant to paragraph (e) of this subsection (2) in an amount not to exceed the amount of annualized general fund savings that result from payment by third parties specifically due to disclosure of coverages pursuant to this section.

(g) The state department shall make quarterly reports concerning the value of computerized matches pursuant to this subsection (2) to the general assembly and the joint budget committee. Such reports shall include, but need not be limited to, the number of individuals against whom computer matches were run, the number of resulting matches, and the resulting corresponding savings to the state department.

(3) (a) The rights assigned by a recipient of medical assistance to the state department pursuant to section ~~26-4-106 (4)~~ 25.5-4-205 (4) shall include the right to appeal an adverse coverage decision by a third party for which the medical assistance program may be responsible for payment, including but not limited to, the internal and external reviews provided for in sections 10-16-113 and 10-16-113.5, C.R.S. The state department or the independent contractor retained pursuant to paragraph (b) of this subsection (3) shall review and, if necessary, appeal an adverse coverage decision, except an adverse coverage decision relating to medicare, Title

XVIII of the federal "Social Security Act", as amended.

(b) The state department shall enter into one or more agreements with an independent contractor to pursue recoveries from third parties pursuant to paragraph (a) of this subsection (3). Any such agreement shall provide that the independent contractor's only compensation shall be a prudent and reasonable percentage of the amount recovered on behalf of the state department as determined by the state department.

(c) (I) An independent contractor retained pursuant to paragraph (b) of this subsection (3) shall maintain a contemporaneous record of the hours of services provided and any costs incurred. When the matter is resolved, the independent contractor shall provide to the state department a statement of the hours of services provided, the amount of costs incurred, the total amount of the contingent fee, and the hourly rate for the services provided. The hourly rate for the services provided shall be determined by dividing the amount of the contingent fee, less the amount of costs incurred, by the number of hours of services provided by the independent contractor. The statement required by this subparagraph (I) shall be available for inspection and copying at reasonable times at the state department.

(II) Compliance with this paragraph (c) does not relieve a contracting attorney of any obligation or legal responsibility imposed by the Colorado rules of professional conduct or any provision of law.

(d) Nothing in this subsection (3) shall be construed to authorize the denial of or delay of payment to a provider by the state department or the delay or interference with the provision of services to a medical assistance recipient.

25.5-4-210. [Formerly 26-4-518.5] Purchase of health insurance for recipients. (1) The state department shall purchase group health insurance for a medical assistance recipient who is eligible to enroll for such coverage if enrollment of such recipient in the group plan would be cost-effective. In addition, the state department may purchase individual health insurance for a medical assistance recipient who is eligible to enroll in a health insurance plan if enrollment of such recipient would be cost-effective to this state. A determination of cost-effectiveness shall be in accordance with federal guidelines established by the secretary of the United States department of health and human services.

(2) Enrollment in a group health insurance plan shall be required of recipients for whom enrollment has been determined to be cost-effective as a condition of obtaining or retaining medical assistance. A parent shall be required to enroll a dependent child recipient, but medical assistance for such child shall not be discontinued if a parent fails to enroll the child.

(3) The state department shall pay any premium, deductible, coinsurance, or other cost-sharing obligation required under the group plan for services covered under the state medical assistance plan. In addition, the state department shall pay any premium, deductible, coinsurance, or other cost-sharing obligation required under an individual plan purchased by the state department for a medical assistance recipient pursuant to subsection (1) of this section. Payment of said services shall be treated as payment for medical assistance. Coverage provided by the purchased

health insurance plan shall be considered as third-party liability for the purposes of section ~~26-4-518~~ 25.5-4-209.

(4) Services not available to a recipient under the purchased plan shall be provided to the recipient if such services would otherwise be provided as medical assistance services pursuant to this article OR ARTICLE 5 OR 6 OF THIS TITLE. Nothing in this section shall be construed to require that services provided under a group health insurance plan for medical assistance recipients shall be made available to recipients not enrolled in the plan. Enrollment in a group health insurance plan pursuant to this section shall not affect the eligibility of a recipient who otherwise qualifies for medical assistance pursuant to this article OR ARTICLE 5 OR 6 OF THIS TITLE.

PART 3 RECOVERY

25.5-4-301. [Formerly 26-4-403] Recoveries - overpayments - penalties - interest - adjustments - liens - review or audit procedures. (1) (a) (I) Except as provided in section ~~26-4-403.3~~ 25.5-4-302 and subparagraph (III) of this paragraph (a), no recipient or estate of the recipient shall be liable for the cost or the cost remaining after payment by medicaid, medicare, or a private insurer of medical benefits authorized by Title XIX of the social security act, by this title, or by rules promulgated by the ~~medical services~~ STATE board, which benefits are rendered to the recipient by a provider of medical services authorized to render such service in the state of Colorado, except those contributions required pursuant to section ~~26-4-518 (1)~~ 25.5-4-209 (1). However, a recipient may enter into a documented agreement with a provider under which the recipient agrees to pay for items or services that are nonreimbursable under the medical assistance program. Under these circumstances, a recipient is liable for the cost of such services and items.

(II) The provisions of subparagraph (I) of this paragraph (a) shall apply regardless of whether medicaid has actually reimbursed the provider and regardless of whether the provider is enrolled in the Colorado medical assistance program.

(III) (A) When a third party is primarily liable for the payment of the costs of a recipient's medical benefits, prior to receiving nonemergency medical care, the recipient shall comply with the protocols of the third party, including using providers within the third party's network or receiving a referral from the recipient's primary care physician. Any recipient failing to follow the third party's protocols is liable for the payment or cost of any care or services that the third party would have been liable to pay; except that, if the third party or the service provider substantively fails to communicate the protocols to the recipient, the items or services are nonreimbursable under this article AND ARTICLES 5 AND 6 OF THIS TITLE and the recipient is not liable to the provider.

(B) A recipient may enter into a written agreement with a third party or provider under which the recipient agrees to pay for items provided or services rendered that are outside of the network or plan protocols. The recipient's agreement to be personally liable for such nonemergency, nonreimbursable items shall be recorded on forms approved by the ~~medical services~~ STATE board and signed and dated by both the recipient and the provider in advance of the services being rendered.

(b) Recipient income applied pursuant to section ~~26-4-518 (1)~~ 25.5-4-209 (1) shall not disqualify any recipient, as defined in section 26-2-103 (8), C.R.S., from receiving benefits under this article, ARTICLE 5 OR 6 OF THIS TITLE, or public assistance under article 2 of ~~this title~~ TITLE 26, C.R.S. If, at any time during the continuance of medical benefits, the recipient becomes possessed of property having a value in excess of that amount set by law or by the rules ~~and regulations~~ of the state department or receives any increase in income, it is the duty of the recipient to notify the county department thereof, and the county department may, after investigation, either revoke such medical benefits or alter the amount thereof, as the circumstances may require.

(c) Any medical assistance paid to which a recipient was not lawfully entitled shall be recoverable from the recipient or the estate of the recipient by the county as a debt due the state pursuant to section ~~26-1-112~~ 25.5-1-115, but no lien may be imposed against the property of a recipient on account of medical assistance paid or to be paid on the recipient's behalf under this article OR ARTICLE 5 OR 6 OF THIS TITLE, except pursuant to the judgment of a court of competent jurisdiction or as provided by section ~~26-4-403.3~~ 25.5-4-302.

(d) If any such medical assistance was obtained fraudulently, interest shall be charged and paid to the county department on the amount of such medical assistance calculated at the legal rate and calculated from the date that payment for medical services rendered on behalf of the recipient is made to the date such amount is recovered.

(2) Any overpayment to a provider, including those of personal needs funds made pursuant to section ~~26-4-504~~ 25.5-6-206, shall be recoverable regardless of whether the overpayment is the result of an error by the STATE department, ~~of health care policy and financing~~ a county department of social services, an entity acting on behalf of either department, or by the provider or any agent of the provider as follows:

(a) (I) If the STATE department ~~of health care policy and financing~~ makes a determination that such overpayment has been made as a result of the provider's false representation, the state department may collect the overpayment, plus a civil monetary penalty equal to one-half the amount of the overpayment, and interest on the sum of the two amounts accruing at the statutory rate from the date the overpayment is identified, by the means specified in this subsection (2). Such sum may be collected for up to the amount of time prescribed in section 13-80-103.5, C.R.S., after the overpayment is identified. Amounts remaining uncollected for more than the time period prescribed in section 13-80-103.5, C.R.S., after the last repayment was made may be considered uncollectible. For the purposes of this subparagraph (I), "false representation" means an inaccurate statement that is relevant to a claim for reimbursement and is made by a provider who has actual knowledge of the truth of false nature of the statement or by a provider acting in deliberate ignorance of or with reckless disregard for the truth of the statement. A provider acts with reckless disregard for truth if the provider fails to maintain records required by the department or if the provider fails to become familiar with rules, manuals, and bulletins issued by the department, board, or the department's fiscal agent.

(II) If the state department makes a determination that such overpayment has been made for some other reason than a false representation by the provider specified in subparagraph (I) of this paragraph (a), the state department may collect the amount of overpayment, plus interest accruing at the statutory rate from the date the provider is notified of such overpayment, by the means specified in this subsection (2). Pursuant to the criteria established in rules ~~and regulations~~ promulgated by the ~~medical services~~ STATE board, the state department may waive the recovery or adjustment of all or part of the overpayment and accrued interest specified in this subparagraph (II) if it would be inequitable, uncollectible, or administratively impracticable. Amounts remaining uncollected for more than five years after the last repayment was made may be considered uncollectible.

(b) In order to collect the amounts specified in paragraph (a) of this subsection (2), the state department may withhold subsequent payments to which the provider is or becomes entitled and apply the amount withheld as an offset. The ~~medical services~~ STATE board shall establish in rules the rate at which an overpayment may be offset, with provision for a reduction of such rate upon a good cause shown by the provider that the rate at which payment will be withheld will result in an undue hardship for the provider. In determining whether to grant a good cause reduction, the state department shall consider the impact of collecting the amount provided by ~~medical services~~ STATE board rules on the quality of patient care and the financial viability of the provider. The state department may also take such other steps administratively as are available for the collection of the amounts specified in paragraph (a) of this subsection (2).

(c) If a provider defaults on repayment of the amounts specified in paragraph (a) of this subsection (2), the state department may bring a suit against the provider in the appropriate court. Court costs shall not be assessed against the state department but shall be assessed against the provider if the court finds in favor of the state department. Any costs collected by the state department shall be paid into the registry of the court. Once the amount has been reduced to judgment, the state department may proceed with all available postjudgment remedies.

(d) Notwithstanding the provisions of section 24-30-202.4, C.R.S., an amount specified in paragraph (a) of this subsection (2) ~~which~~ THAT the state department has determined to be uncollectible may be referred to the controller for collection. Net proceeds of debts collected by the controller pursuant to this paragraph (d) shall be paid into the fund from which the overpayment was made.

(e) Any provider adversely affected by actions taken pursuant to this subsection (2), except when a suit is filed against the provider pursuant to paragraph (c) of this subsection (2), may appeal the determination of the state department pursuant to the provisions in section 24-4-105, C.R.S.

(f) If the state department, either directly or through a contracting agent, undertakes a review or an audit of a provider to determine whether an overpayment has been made to that provider, the review or audit shall be subject to the procedures required in subsection ~~(2.5)~~ (3) of this section.

~~(2.5)~~ (3) (a) A review or audit of a provider shall be subject to the following procedures:

(I) The reviewer or auditor shall conduct a review or audit in accordance with applicable state and federal law.

(II) The reviewer or auditor shall apply uniform standards and procedures to each class of providers subject to a review or an audit to determine an overpayment.

(III) The reviewer or auditor shall prepare findings for the entire period under review or audit, and a provider shall be subject to only one demand for repayment in connection with the review or audit.

(IV) The reviewer or auditor shall initiate each review or audit requiring an inspection of the provider's records by delivering to the provider a written request describing in detail such records and offering the provider the option of providing either a reproduction of such records or inspection by the reviewer or auditor at the provider's site. In the event such records are available from a county department of social services or another agency, subdivision, or contractor of the state, the reviewer or auditor shall request such records from such other agencies as may be appropriate prior to making a request to the provider. The reviewer or auditor shall conduct on-site inspections at reasonable times during regular business hours, and the reviewer or auditor shall make arrangements necessary for the reproduction of such records on site. If the provider chooses to provide a reproduction of the records requested by the reviewer or auditor instead of on-site inspection, the reviewer or auditor shall give the provider a reasonable period of time to provide such records, taking into account the scope of the request, the time frame covered, and the reproduction arrangements available to the provider.

(V) A physician's record or other order for health care services, drugs, or medicinal supplies in a form transmitted electronically shall be sufficient to validate the provider's records regarding the ordering of the health care services, drugs, or medicinal supplies.

(VI) Whenever possible, the reviewer or auditor shall base a determination of an overpayment to a provider upon a review of actual records of the department, its agents, or the provider. In the event sufficient records are not available to the reviewer or auditor, an overpayment determination may be based upon a sampling of records so long as the sampling and any extrapolation therefrom is reasonably valid from a statistical standpoint and is in accordance with generally accepted auditing standards.

(VII) If a reviewer or auditor determines that there has been an overpayment to the provider, then, at the time demand for repayment is made, the state department shall offer the provider an informal reconsideration of the review or audit findings. In the event an informal reconsideration is requested, the state department shall not implement recovery of the overpayment until such informal reconsideration has been completed.

(VIII) In accordance with paragraph (e) of subsection (2) of this section, any provider adversely affected by the actions of the state department or its contracting agent in connection with a review or an audit, including whether the state department or its contracting agent adhered to the provisions of this subsection ~~(2.5)~~ (3) in making an overpayment determination, may appeal such actions pursuant to

the provisions of section 24-4-105, C.R.S.

(b) The state department is authorized to engage the services of a qualified agent through a competitive contract issued pursuant to the state's procurement code for the purpose of conducting a review or audit of a provider to assist in determining whether there has been an overpayment to a provider and the amount of that overpayment. In addition to such terms and conditions as the state department may deem necessary, any contract shall be subject to the requirements for conducting a review or an audit in accordance with paragraph (a) of this subsection ~~(2.5)~~ (3). The state department is further authorized to enter into a contract with a qualified agent for the purpose of conducting a review or an audit of a provider that provides that the compensation of the contracting agent shall be contingent and based upon a percentage of the amount of the recovery collected from the provider. A contract issued by the state department for the purpose of conducting a review or an audit of a provider to determine whether the provider has received an overpayment shall also be subject to the following conditions:

(I) The compensation paid to the contracting agent under a contingency-based contract shall not exceed eighteen percent of the amount finally collected from the provider overpayment, and the state department may establish a limit on the amount of annual compensation that may be paid to a contracting agent under a contingency-based contract and may further establish a limit on the amount that may be paid to a contracting agent under a contingency-based contract for recovery from any one provider.

(II) Reimbursement of the contracting agent's costs in performing the review or audit under a contingency-based contract shall be deemed included in the percentage compensation due the agent under the contract.

(III) No employee or agent of the contracting agent involved in the performance of a contingency-based contract shall be compensated by the contracting agent based upon the amount recovered under the contract.

(IV) The state department shall retain all authority for providing notice and otherwise making demand upon a provider for recovery of an overpayment, and the state department shall review and approve any written demand, request, or determination by the contracting agent regarding a review or an audit of a provider under this subsection ~~(2.5)~~ (3).

(V) In any contingency-based contract authorized pursuant to this paragraph (b), the state of Colorado shall not be obligated to pay the contracting agent for amounts not actually collected from the provider.

~~(3)~~ (4) If medical assistance is furnished to or on behalf of a recipient pursuant to the provisions of this article AND ARTICLES 5 AND 6 OF THIS TITLE for which a third party is liable, the state department has an enforceable right against such third party for the amount of such medical assistance, including the lien right specified in subsection ~~(4)~~ (5) of this section. Whenever the recipient has brought or may bring an action in court to determine the liability of the third party, the state department, without any other name, title, or authority to enforce the state department's right, may enter into appropriate agreements and assignments of rights

with the recipient and the recipient's attorney, if any. Any such agreement shall be filed with the court in which such an action is pending. The attorney named in such an agreement upon designation as a special assistant attorney general by the attorney general shall have the right to prove both the recipient's claim and the state department's claim. The state department, without any other name, title, or authority, may take any necessary action to determine the existence and amount of the state department's claims under this section, whether such claims are founded on judgment, contract, lien, or otherwise, and take any other action that is appropriate to recover from such third parties. To enforce such right, the attorney general, pursuant to section 24-31-101, C.R.S., on behalf of the state department may institute and prosecute, or intervene of right in legal proceedings against the third party having legal liability, either in the name of the state department or in the name of the recipient or his or her assignee, guardian, personal representative, estate, or survivors. When the state department intervenes in legal proceedings against the third party, it shall not be liable for any portion of the attorney fees or costs of the recipient.

~~(4)~~ (5) (a) When the state department has furnished medical assistance to or on behalf of a recipient pursuant to the provisions of this article, AND ARTICLES 5 AND 6 OF THIS TITLE, for which a third party is liable, the state department shall have an automatic statutory lien for all such medical assistance. The state department's lien shall be against the amount of the judgment, award, or settlement in a suit or claim against such third party and shall be payable after deducting from the judgment, award, or settlement for the recipient's attorney fees and reasonable litigation costs incurred in the preparation and prosecution of the action or claim.

(b) No judgment, award, or settlement in any action or claim by a recipient to recover damages for injuries, where the state department has a lien, shall be satisfied without first satisfying the state department's lien. Failure by any party to the judgment, award, or settlement to comply with this section shall make each such party liable for the full amount of medical assistance furnished to or on behalf of the recipient for the injuries that are the subject of the judgment, award, or settlement.

(c) Except as otherwise provided in this article, the entire amount of any judgment, award, or settlement of the recipient's action or claim, with or without suit, regardless of how characterized by the parties or whether the amount includes medical costs, shall be subject to the state department's lien.

(d) Where the action or claim is brought by the recipient alone and the recipient incurs a personal liability to pay attorney fees, the state department will pay its reasonable share of attorney fees not to exceed twenty-five percent of the state department's lien. The state department shall not be liable for costs.

(e) The state department's right to recover under this section is independent of the recipient's right.

~~(5)~~ (6) When the applicant or recipient, or his or her guardian, executor, administrator, or other appropriate representative, brings an action or asserts a claim against any third party, such person shall give to the state department written notice of the action or claim by personal service or certified mail within fifteen days after filing the action or asserting the claim. Failure to comply with this subsection ~~(5)~~

(6) shall make the recipient, legal guardian, executor, administrator, attorney, or other representative liable for the entire amount of medical assistance furnished to or on behalf of the recipient for the injuries that gave rise to the action or claim. The state department may, after thirty days' written notice to such person, enforce its rights under subsection ~~(4)~~ (5) of this section and this subsection ~~(5)~~ (6) in the district court of the city and county of Denver; except that liability of a person other than the recipient shall exist only if such person had knowledge that the recipient had received medical assistance or if excusable neglect is found by the court. The court shall award the state department its costs and attorney fees incurred in the prosecution of any such action.

~~(6)~~ (7) When a legally responsible relative of the recipient agrees or is ordered to provide medical support or health insurance coverage for his OR HER dependents or other persons, and such dependents are applicants for, recipients of, or otherwise entitled to receive medical assistance pursuant to this article AND ARTICLES 5 AND 6 OF THIS TITLE, the state department shall be subrogated to any rights that the responsible persons may have to obtain reimbursement from a third party or insurance carrier for the cost of medical assistance provided for such dependents or persons. Where the state department gives written notice of subrogation, any third party or insurance carrier liable for reimbursement for the cost of medical care shall accord to the state department all rights and benefits available to the responsible relative that pertain to the provision of medical care to any persons entitled to medical assistance pursuant to this article AND ARTICLES 5 AND 6 OF THIS TITLE for whom the relative is legally responsible.

~~(7)~~ (8) All recipients of medical assistance under the medicaid program shall be deemed to have authorized their attorneys, all third parties, including but not limited to insurance companies, and providers of medical care to release to the state department all information needed by the state department to secure and enforce its rights under subsections ~~(3)~~ (4) and ~~(4)~~ (5) of this section.

~~(8)~~ (9) Nothing in part 6 of article 4 of title 10, C.R.S., shall be construed to limit the right of the state department to recover the medical assistance furnished to or on behalf of a recipient as the result of the negligence of a third party.

~~(9)~~ (10) No action taken by the state department pursuant to subsection ~~(3)~~ (4) of this section or any judgment rendered in such action shall be a bar to any action upon the claim or cause of action of the applicant or recipient or his OR HER guardian, personal representative, estate, dependent, or survivors against the third party having legal liability, nor shall any such action or judgment operate to deny the applicant or recipient the recovery for that portion of his OR HER medical costs or other damages not provided as medical assistance under this article OR ARTICLE 5 OR 6 OF THIS TITLE.

~~(10)~~ (11) (a) The state department shall have a right to recover any amount of medical assistance paid on behalf of a recipient because:

(I) The trustee of a trust for the benefit of the recipient has used the trust property in a manner contrary to the terms of the trust;

(II) A person holding the recipient's power of attorney has used the power for

purposes other than the benefit of the recipient.

(b) To enforce the right under this subsection ~~(10)~~ (11) the county or state department may institute or intervene in legal proceedings against the trustee or person holding the power of attorney. Any amount of medical assistance recovered pursuant to this subsection ~~(10)~~ (11) shall be distributed between the state and county in proportion to the amount of medical assistance paid by each respectively, if any.

(c) No action taken by the county or state department pursuant to this subsection ~~(10)~~ (11) or any judgment rendered in such action or proceeding shall be a bar to any action upon the claim or cause of action of the recipient or his OR HER guardian, personal representative, estate, dependent, or survivors against the trustee or person holding the power of attorney.

~~(11)~~ (12) (a) An entity that provides managed care, as defined in section ~~26-4-114~~ 25.5-5-403, that has entered into a risk contract with the state department shall have the same rights of the department set forth in this section except with respect to the rights described in subsections ~~(4)~~ (5) and ~~(5)~~ (6) of this section. In addition, the attorney general may not enforce the rights set forth in this subsection ~~(11)~~ (12). Venue for an action brought by or on behalf of an entity pursuant to this subsection ~~(11)~~ (12) shall be governed by the Colorado rules of civil procedure.

(b) Within fifteen days after filing an action or asserting a claim against a third party, a recipient under a managed care plan or a guardian, executor, administrator, or other appropriate representative of the recipient shall provide to the entity that administers the managed care plan written notice of the action or claim. Notice shall be by personal service or certified mail.

(c) In cases where the state department has recovery rights against a third party pursuant to subsections ~~(3)~~ (4) and ~~(4)~~ (5) of this section and an entity that provides managed care has subrogation rights against the same party pursuant to paragraph (a) of this subsection ~~(11)~~ (12), the recovery rights of the state department shall take precedence over the rights of the managed care plan.

~~(12)~~ (13) To the extent allowable under federal law, the state department shall recover from a legal immigrant's sponsor all medical assistance paid on behalf of a sponsored legal immigrant who is enrolled in the medical assistance program.

25.5-4-302. [Formerly 26-4-403.3] Recovery of assets. (1) The general assembly hereby finds, determines, and declares that the cost of providing medical assistance to qualified recipients throughout the state has increased significantly in recent years; that such increasing costs have created an increased burden on state revenues while reducing the amount of such revenues available for other state programs; that recovering some of the medical assistance from the estates of medical assistance recipients would be a viable mechanism for such recipients to share in the cost of such assistance; and that such an estate recovery program would be a cost-efficient method of offsetting medical assistance costs in an equitable manner. The general assembly also declares that in order to ensure that medicaid is available for low-income individuals reasonable restrictions consistent with federal law should be placed on the ability of persons to become eligible for

medicaid by means of making transfers of property without fair and valuable consideration.

(2) (a) Medical assistance paid on behalf of any individual who was fifty-five years of age or older when the individual received such assistance may be recovered by the state department from the estate of such individual in accordance with paragraph (c) of this subsection (2).

(b) Medical assistance paid on behalf of any individual who is institutionalized may be recovered by the state department from the estate of such individual in accordance with paragraph (c) of this subsection (2).

(c) The state department shall establish an estate recovery program only insofar as such program is in accordance with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396p, as amended, and shall not take any action to recover medical assistance when the amount of assistance to be recovered is economically inappropriate in relation to expenses of recovery.

(3) The state department is authorized to file liens against any property of an individual who is institutionalized and from whom the state department may recover medical assistance pursuant to paragraph (b) of subsection (2) of this section.

(4) The state department may compromise, settle, or waive any recovery of medical assistance authorized pursuant to subsection (2) of this section upon good cause shown.

(5) Subject to any limitation concerning estate recovery in Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396p, as amended, the amount of any medical assistance paid pursuant to the provisions of this article AND ARTICLES 5 AND 6 OF THIS TITLE is a claim against the estate pursuant to the provisions of section 15-12-805 (1), C.R.S.

(6) The state ~~department~~ BOARD shall promulgate rules to implement the provisions of this section, including rules limiting the eligibility for medical assistance if the person made a voluntary assignment or transfer of property without fair and valuable consideration prior to applying for medical assistance. A contract for an exempt burial fund for an individual shall include a provision restricting the full amount to the cost of the burial and stating that any portion not expended for the burial costs shall be refunded to the ~~Colorado~~ STATE department of ~~health care policy and financing~~ by the mortuary as reimbursement for the cost of medical assistance provided to the individual. Said rules shall be in accordance with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396p, as amended.

~~(7) (Deleted by amendment, L. 94, p. 1601, § 8, effective July 1, 1994.)~~

~~(8)~~ (7) Effective upon the implementation of a private-public partnership program for financing long-term care pursuant to section ~~26-4-506.7~~ 25.5-6-110, this section shall apply to participants of such program only after excluding from the amount that may otherwise be recovered from such person's estate an amount allowed by rules adopted by the ~~medical services~~ STATE board in accordance with section ~~26-4-506.7~~ 25.5-6-110.

25.5-4-303. [Formerly 26-4-403.4] State income tax refund intercept - garnishment of earning - failure to provide medical support for child.

(1) (a) At any time prescribed by the department of revenue, but not less frequently than annually, the state department may certify to the department of revenue information regarding any person who:

(I) Is obligated to the state agency responsible for administering medical assistance in this state for medical support based on medical assistance provided to the obligor's dependent child; and

(II) Has received payment from a third party to cover the health care costs of the child but has neither applied such payment to cover the child's health care costs nor to reimburse the state department, the custodial parent of the child, or the provider of medical care.

(b) The information provided to the department of revenue shall include the name and the social security number of the person described in paragraph (a) of this subsection (1), the amount of medical assistance provided to the child during the period for which medical support was ordered but not provided as described in subparagraph (II) of paragraph (a) of this subsection (1), and any other identifying information required by the department of revenue.

(2) Prior to a final certification of the information described in subsection (1) of this section to the department of revenue, the state department shall notify the obligated person, in writing, that the state intends to refer the person's name to the department of revenue in an attempt to offset the person's medical support obligation against the person's state income tax refund. Such notification shall include information on the parent's right to object to the offset.

(3) Upon notification by the department of revenue of amounts deposited with the state treasurer pursuant to section 39-21-108 (3), C.R.S., the state department may recover the amount of the medical assistance described in paragraph (b) of subsection (1) of this section.

(4) The state department may garnish the wages and other earnings of a person described in paragraph (a) of subsection (1) of this section. The garnishment of wages and earning shall be in accordance with articles 54 and 54.5 of title 13, C.R.S.

(5) The state ~~department~~ BOARD shall adopt rules as are necessary for the implementation of this section.

25.5-4-304. [Formerly 26-4-1102 and 26-4-1103 (3)] False medicaid claims - definitions. As used in ~~this part~~ THIS SECTION AND SECTIONS 25.5-4-305 AND 25.5-4-306, unless the context otherwise requires:

(1) "Benefit" means any medical assistance reimbursed or reimbursable under this article AND ARTICLES 5 AND 6 OF THIS TITLE.

(2) "Claim" means any communication, whether oral, written, electronic, or magnetic, that includes a request or demand for money or property as

reimbursement for a benefit. Each item listed within any communication that identifies multiple items as separately reimbursable is deemed a separate claim.

(3) "Cost document" means any cost report or similar document that states income or expenses and is or may be used to determine a rate of payment for a provider under this article AND ARTICLES 5 AND 6 OF THIS TITLE.

~~(3) [Formerly 26-4-1103 (3) (a)] As used in this part 11, unless the context otherwise requires:~~

~~(a)~~ (4) "Intentionally" means that, with respect to information, the person has actual knowledge of the falsity of the information and acts with specific intent to defraud.

~~(4)~~ (5) "Person" means any individual or entity holding or capable of holding a legal or beneficial interest in property.

~~(b)~~ (6) [Formerly 26-4-1103 (3) (b)] "Reckless disregard" means that the person acts with conscious indifference to the truth or the falsity of the information. "Reckless disregard" does not require proof of specific intent to defraud.

25.5-4-305. [Formerly 26-4-1103 (1) and (2)] False medicaid claims - unlawful act - exceptions. (1) It is unlawful for any person to:

(a) Intentionally or with reckless disregard make or cause to be made any false representation of a material fact in connection with a claim;

(b) Intentionally or with reckless disregard present or cause to be presented to the state department a false claim for payment or approval;

(c) Intentionally or with reckless disregard present or cause to be presented any cost document required by the medical assistance program that the person knows contains a false material statement;

(d) As to services for which a license is required, intentionally or with reckless disregard make or cause to be made a claim with knowledge that the individual who furnished the services was not licensed to provide such services;

(e) Except as provided in subsection (2) of this section, intentionally or with reckless disregard offer, solicit, receive, or pay any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind:

(I) In return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this article AND ARTICLES 5 AND 6 OF THIS TITLE; or

(II) In return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, ordering, or arranging for any good, facility, service, or item for which payment may be made in whole or in part under this article AND ARTICLE 5 AND 6 OF THIS TITLE.

(2) It shall not be unlawful under paragraph (e) of subsection (1) of this section if the remuneration obtained by the provider or other entity is:

(a) Permitted pursuant to section ~~26-4-410.5~~ 25.5-4-414 or any safe harbor regulations of the federal department of health and human services, OR ANY SUCCESSOR AGENCY;

(b) Properly disclosed and appropriately reflected in the claims or cost documents submitted under this article, OR ARTICLES 5 OR 6 OF THIS TITLE;

(c) Paid by an employer to an employee who has a bona fide employment relationship with such employer for employment in providing the medical assistance; or

(d) Paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of providers and:

(I) The person has a written contract with the providers that specifies the amount to be paid to the person which amount may be a fixed amount or a fixed percentage of the value of the purchases made by the person; or

(II) In the case of a provider of services, the person discloses, in such form and manner as the state department requires, to the provider and, upon request, to the state department the amount received from each such vendor with respect to purchases made by or on behalf of the provider.

25.5-4-306. [Formerly 26-4-1104] Restitution - civil penalties. (1) (a) The state department may commence a civil action against any person believed by the state department to have violated the provisions of ~~this part~~ SECTION 25.5-4-305.

(b) Upon finding that such person has intentionally violated the provisions of this ~~part~~ SECTION OR SECTION 25.5-4-304 OR 25.5-4-306, the court shall order such person to pay to the state department:

(I) Full restitution in the amount of all medical assistance found by the court to have been received by the person because of such violation; and

(II) A civil penalty of five thousand dollars per claim or two times the amount of all medical assistance found by the court to have been received by the person because of such violation or both.

(c) Upon finding that such person has, with reckless disregard, violated the provisions of this ~~part~~ SECTION OR SECTION 25.5-4-304 OR 25.5-4-306, the court shall order such person to pay to the state department:

(I) Full restitution in the amount of all medical assistance found by the court to have been received by the person because of such violation; and

(II) A civil penalty not to exceed one thousand dollars per claim, but in no event more than fifty thousand dollars, or two times the amount of all medical assistance found by the court to have been received by the person because of such violation.

(2) Notwithstanding the provisions of subsection (1) of this section, the civil penalty provided for in subparagraph (II) of paragraph (b) of subsection (1) of this section or in subparagraph (II) of paragraph (c) of subsection (1) of this section shall be limited to not more than the amount of all medical assistance found by the court to have been received by the person because of such violation if:

(a) The person committing the violation furnished to the department, its fiscal agent, or the medicaid fraud unit of the department of law all information known to such person about the violation within thirty days after the date on which the person first obtained the information; and

(b) Such person fully cooperated with any investigation of such violation and at the time that the person furnished the department with the information no criminal prosecution, civil action, or administrative action had commenced with respect to the violation, and the person did not have actual knowledge of the existence of an investigation into such violation.

(3) (a) In any action commenced under this section whether tried by a court or to a jury, the amount of restitution and penalty shall be determined by the court.

(b) In any action commenced under this section, the standard of proof shall be by a preponderance of the evidence.

(c) In order to assist the court in determining the amount of restitution, the department of law, after appropriate investigation, shall recommend to the court an amount that would make the state department whole with respect to the money wrongfully received pursuant to this article OR ARTICLE 5 OR 6 OF THIS TITLE and all other measurable monetary damages directly related to the cause of action. If the defendant disagrees with the recommendation of the department of law, the defendant shall be entitled to introduce evidence in mitigation of the amount recommended.

(4) The cause of action, penalties, and remedies provided by this ~~part 11~~ SECTION AND SECTIONS 25.5-4-304 AND 25.5-4-306 are not exclusive, but are in addition to any other available civil, criminal, or administrative action, penalty, or remedy; except that, if a penalty is also available under federal law, the penalty under this ~~part 11~~ SECTION AND SECTIONS 25.5-4-304 AND 25.5-4-306 and the federal law shall not be imposed upon the same dollar of overpayment. Any penalty under federal law shall apply to the federal portion of the overpayment, and the penalty under this ~~part 11~~ SECTION AND SECTIONS 25.5-4-304 AND 25.5-4-306 shall apply to the state portion of the overpayment.

PART 4 PROVIDERS - REIMBURSEMENT

25.5-4-401. [Formerly 26-4-404] Providers - payments - rules. (1) (a) The state department shall establish rules ~~and regulations~~ for the payment of providers under this article AND ARTICLES 5 AND 6 OF THIS TITLE. Within the limits of available funds, such rules ~~and regulations~~ shall provide reasonable compensation to such providers, but no provider shall, by this section or any other provision of this article OR ARTICLE 5 OR 6 OF THIS TITLE, be deemed to have any vested right to act

as a provider under this article AND ARTICLES 5 AND 6 OF THIS TITLE or to receive any payment in addition to or different from that which is currently payable on behalf of a recipient at the time the medical benefits are provided by said provider.

(b) (I) ~~(A)~~ On and after July 1, 1992, the state department rules ~~and regulations~~ established for the payment of providers under this article AND ARTICLES 5 AND 6 OF THIS TITLE shall provide that services that are compensable under both Title XIX and Title XVIII of the social security act shall be paid at either the rate established under Title XIX or the rate established under Title XVIII, whichever is lower.

~~(B)~~ (II) If any provision of this ~~subparagraph (I)~~ PARAGRAPH (b) is found to be in conflict with any federal law or regulation, such conflicting portion of this ~~subparagraph (I)~~ PARAGRAPH (b) is declared to be inoperative to the extent of the conflict.

~~(H) The general assembly shall annually appropriate to the state department of health care policy and financing one-half of the amount that would have been paid to providers if the services described in subparagraph (I) of this paragraph (b) were compensated under both Title XIX and Title XVIII of the social security act, which shall be applied to the maintenance of a fixed market rate primary care provider incentive payment. Any balance in the savings may be used to cover the administrative costs of implementing managed care pursuant to the provisions of subpart 2 of part 1 of this article and the costs of the expansion of the incentive program to providers of dental services for children under the early periodic screening, diagnosis, and treatment program.~~

(c) The state department shall exercise its overexpenditure authority under section 24-75-109, C.R.S., and shall not intentionally interrupt the normal provider payment schedule unless notified jointly by the director of the office of state planning and budgeting and the state controller that there is the possibility that adequate cash will not be available to make payments to providers and for other state expenses. If it is determined that adequate cash is not available and the state department does interrupt the normal payment cycle, the state department shall notify the joint budget committee of the general assembly and any affected providers in writing of its decision to interrupt the normal payment schedule. Nothing in this paragraph (c) shall be interpreted to establish a right for any provider to be paid during any specific billing cycle.

(2) As to all payments made pursuant to this article AND ARTICLES 5 AND 6 OF THIS TITLE, the state department rules ~~and regulations~~ for the payment of providers may include provisions that encourage the highest quality of medical benefits and the provision thereof at the least expense possible.

(3) (a) As used in this subsection (3), "capitated" means a method of payment by which a provider directly delivers or arranges for delivery of medical care benefits for a term established by contract with the state department based on a fixed rate of reimbursement per recipient.

(b) (I) In order to provide medical benefits under this article AND ARTICLES 5 AND 6 OF THIS TITLE on a capitated basis and subject to the condition imposed in subparagraph (II) of this paragraph (b), the state department is authorized to solicit

negotiated contracts with providers based upon the requirements of this subsection (3). The state department may contract with one or more providers concerning the same medical services in a single geographic area.

(II) The state department may award a contract to one or more providers pursuant to subparagraph (I) of this paragraph (b) when the executive director determines that such contract will reduce the costs of providing medical benefits under this article AND ARTICLES 5 AND 6 OF THIS TITLE.

(III) The state department may define groups of recipients by geographic area or other categories and may require that all members of the defined group obtain medical services through one or more provider contracts entered into pursuant to this subsection (3).

~~(IV) Repealed.~~

(4) (a) The general assembly hereby finds, determines, and declares that access to health care services would be improved and costs of health care would be restrained if the recipients of the medicaid program would choose a primary care physician through a managed care provider. For purposes of this subsection (4), "managed care provider" means either a primary care physician program, a health maintenance organization, or a prepaid health plan.

(b) Subject to the provisions of paragraph (c) of this subsection (4), the executive director of the state department has the authority to require a recipient of the medicaid program to select a managed care provider and to assign a recipient to a managed care provider if the recipient has failed to make a selection within a reasonable time. To the extent possible, this requirement shall be implemented on a statewide basis.

(c) The state department shall ensure the following:

~~(f) (Deleted by amendment, L. 97, p. 1367, § 5, effective June 3, 1997.)~~

~~(ff)~~ (I) A managed care provider shall establish and implement consumer friendly procedures and instructions for disenrollment and shall have adequate staff to explain issues concerning service delivery and disenrollment procedures to recipients, including staff to address the communications needs and requirements of recipients with disabilities.

~~(fff)~~ (II) All recipients shall be adequately informed about service delivery options available to them consistent with the provisions of this subparagraph ~~(fff)~~ (II). If a recipient does not respond to a state department request for selection of a delivery option within forty-five calendar days, the state department shall send a second notification to the recipient. If the recipient does not respond within twenty days of the date of the second notification, the state department shall ensure that the recipient remains with the recipient's primary care physician, regardless of whether said primary care physician is enrolled in a health maintenance organization.

(5) The state department BOARD may promulgate rules and regulations to provide for the implementation and administration of subsections (3) and (4) of this section.

(6) The state department shall make good faith efforts to obtain a waiver or waivers from any requirements of Title XIX of the social security act which would prohibit the implementation of subsections (3) and (4) of this section. Such waiver or waivers shall be obtained from the federal department of health and human services, OR ANY SUCCESSOR AGENCY. If such waivers are not granted, the state department shall not act to implement or administer subsections (3) and (4) of this section to the extent that Title XIX prohibits it.

25.5-4-402. [Formerly 26-4-405] Providers - hospital reimbursement. On or after July 1, 1987, the state department shall pay all licensed or certified hospitals under this article AND ARTICLES 5 AND 6 OF THIS TITLE, except those hospitals operated by the department of human services, pursuant to a system of prospective payment, generally based on the elements of the medicare system of diagnosis-related groups. While developing the system of prospective payment, the state department shall constitute an advisory committee, whose members shall include hospital providers and be appointed by the executive director. The system of prospective payment shall consider utilizing the system of children's diagnosis-related groups, as developed by the national association of children's hospitals, for pediatric hospitalization, unless the ~~medical services~~ STATE board finds that such groups are statistically invalid. If the state department determines that the medicare system of diagnosis-related groups has been expanded or revised sufficiently to reasonably apply to additional categories of providers under this article AND ARTICLES 5 AND 6 OF THIS TITLE or if the state department develops a diagnosis-related groups system for additional categories of providers, which system includes hospitals operated by the department of human services, then the state department shall begin payment to such categories of providers under this article AND ARTICLES 5 AND 6 OF THIS TITLE pursuant to the system of prospective payment developed under this section. The state department shall develop and administer a system for assuring appropriate utilization and quality of care provided by those providers who are reimbursed pursuant to the system of prospective payment developed under this section. The state ~~department~~ BOARD shall promulgate rules ~~and regulations~~ to provide for the implementation of this section.

25.5-4-403. [Formerly 26-4-409] Providers - community mental health center and clinics - reimbursement. For the purpose of reimbursing community mental health center and clinic providers, the state department shall establish a price schedule annually with the department of human services in order to reimburse each provider for its actual or reasonable cost of services.

25.5-4-404. [Formerly 26-4-515] Payments for clinic services - restrictions on use. All payments received by county or regional health departments or local boards of health for clinic services, as defined in section ~~26-4-513 (3)~~ 25.5-5-301 (3), furnished to patients shall be used only to offset costs incurred for provision of services by such county or regional health departments or local boards of health or to cash fund health care services in the county where the services were provided.

25.5-4-405. [Formerly 26-4-409.5] Mental health managed care service providers - requirements. (1) Each contract between the state department and a managed care organization providing mental health services to a recipient under the medical assistance program shall comply with all federal requirements, including but not limited to:

(a) Ensuring that a recipient with complex or multiple needs who requires mental health services shall have access to mental health professionals with appropriate training and credentials and shall provide the recipient with such services in collaboration with the recipient's other providers;

(b) Informing each recipient of his or her right to and the process for appeal upon notification of denial, termination, or reduction of a requested service; and

(c) Administering initial stabilization treatment for a recipient and transferring the recipient for appropriate continued services.

(2) For mental health managed care recipients, the state department shall have a patient representative program for recipient grievances that complies with all federal requirements and that shall:

(a) Be posted in a conspicuous place at each location at which mental health services are provided;

(b) Allow for a patient representative to serve as a liaison between the recipient and the provider;

(c) Describe the qualifications for a patient representative;

(d) Outline the responsibilities of a patient representative;

(e) Describe the authority of a patient representative; and

(f) Establish a method by which each recipient is informed of the patient representative program and how a patient representative may be contacted.

25.5-4-406. Rate setting - medicaid residential treatment service providers - monitoring and auditing - report. (1) THE STATE DEPARTMENT SHALL APPROVE A RATE-SETTING PROCESS CONSISTENT WITH MEDICAID REQUIREMENTS FOR PROVIDERS OF MEDICAID RESIDENTIAL TREATMENT SERVICES IN THE STATE OF COLORADO AS DEVELOPED BY THE DEPARTMENT OF HUMAN SERVICES. THE RATE-SETTING PROCESS DEVELOPED PURSUANT TO THIS SECTION MAY INCLUDE, BUT SHALL NOT BE LIMITED TO:

(a) A RANGE FOR REIMBURSEMENT THAT REPRESENTS A BASE-TREATMENT RATE FOR SERVING A CHILD WHO IS SUBJECT TO OUT-OF-HOME PLACEMENT DUE TO DEPENDENCY AND NEGLECT, A CHILD PLACED IN A RESIDENTIAL CHILD CARE FACILITY PURSUANT TO THE "CHILD MENTAL HEALTH TREATMENT ACT", ARTICLE 10.3 OF TITLE 27, C.R.S., OR A CHILD WHO HAS BEEN ADJUDICATED A DELINQUENT, WHICH INCLUDES A DEFINED SERVICE PACKAGE AND DOES NOT LINK THE RATE TO THE CHILD'S EVALUATION OR ASSESSMENT;

(b) A REQUEST FOR PROPOSAL TO CONTRACT FOR SPECIALIZED SERVICE NEEDS OF A CHILD, INCLUDING BUT NOT LIMITED TO: SUBSTANCE-ABUSE TREATMENT SERVICES; SEX OFFENDER SERVICES; AND SERVICES FOR THE DEVELOPMENTALLY DISABLED; AND

(c) NEGOTIATED INCENTIVES FOR ACHIEVING OUTCOMES FOR THE CHILD AS DEFINED BY THE STATE DEPARTMENT, COUNTIES, AND PROVIDERS.

(2) THE MEDICAID RATE-SETTING PROCESS APPROVED BY THE STATE DEPARTMENT SHALL INCLUDE RECOMMENDATIONS FOR A TWO- OR THREE-YEAR IMPLEMENTATION TIMELINE WITH IMPLEMENTATION BEGINNING IN STATE FISCAL YEAR 2007-08.

(3) THE STATE DEPARTMENT AND THE DEPARTMENT OF HUMAN SERVICES, IN CONSULTATION WITH THE REPRESENTATIVES OF THE COUNTIES AND THE PROVIDER COMMUNITY, SHALL REVIEW THE RATE-SETTING PROCESS EVERY TWO YEARS AND SHALL SUBMIT ANY RECOMMENDED CHANGES TO THE JOINT BUDGET COMMITTEE OF THE GENERAL ASSEMBLY.

25.5-4-407. [Formerly 26-4-412] Services by licensed psychologists without a doctor's referral. ~~(1)~~ (a) The executive director of the state department may authorize the providing of services of licensed psychologists without the requirement that the services be referred by a doctor of medicine or a doctor of osteopathy, but such services shall be subject to the cost containment program specified under section ~~26-4-516~~ 25.5-4-408. The executive director may except from the authorization those services ~~he~~ THE DIRECTOR determines to be necessary for the purpose of promoting the primary care physician program.

~~(b) (Deleted by amendment, L. 92, p. 2155, § 2, effective April 16, 1992.)~~

25.5-4-408. [Formerly 26-4-516] Services provided by licensed psychologists - cost containment program. (1) Working in conjunction with licensed psychologists in the state, the state ~~department~~ BOARD shall promulgate rules ~~and regulations~~ to establish and implement mechanisms for containing the costs of services provided by licensed psychologists under the medical assistance programs established pursuant to this article AND ARTICLES 5 AND 6 OF THIS TITLE. The cost containment mechanism shall insure that the costs to the medical assistance program will result in no increase in the total cost of the program solely as a result of the reimbursement for services of licensed psychologists pursuant to section ~~26-4-412~~. ~~Such~~ 25.5-4-407. THE cost containment mechanisms may include the following:

(a) Limiting the number of days a licensed psychologist may be reimbursed per patient for inpatient hospitalization, partial hospitalization, and outpatient visits without an order for continued treatment from a doctor of medicine or osteopathy;

(b) Limiting the number of hours a licensed psychologist may be reimbursed for diagnostic testing and evaluation per patient per year;

(c) Provision of group therapy when needed or appropriate;

(d) Provision of licensed psychologists' services from a pool of those licensed psychologists requesting to be included in such pool.

~~(2) and (3) (Deleted by amendment, L. 92, p. 2155, § 3, effective April 16, 1992.)~~

25.5-4-409. [Formerly 26-4-413] Authorization of services - nurse anesthetists - nurse practitioners. (1) When services by a certified registered

nurse anesthetist are provided pursuant to an order by a physician in accordance with this article, ARTICLES 5 AND 6 OF THIS TITLE, and section 12-38-103 (10), C.R.S., the executive director of the state department shall authorize reimbursement for said services. Payment for such services shall be made directly to the nurse anesthetist, if requested by the nurse anesthetist; except that this section shall not apply to nurse anesthetists when acting within the scope of their employment as salaried employees of public or private institutions or physicians.

(2) When services by a certified pediatric nurse practitioner or a certified family nurse practitioner are provided in accordance with this article, ARTICLES 5 AND 6 OF THIS TITLE, and section 12-38-103 (10), C.R.S., the executive director of the state department shall authorize reimbursement for said services. Payment for such services shall be made directly to the nurse practitioner, if requested by the nurse practitioner; except that this section shall not apply to nurse practitioners when acting within the scope of their employment as salaried employees of public or private institutions or physicians.

25.5-4-410. [Formerly 26-4-414] Services of audiologists and speech pathologists without supervision. (1) When medical or diagnostic services by an audiologist or speech pathologist are provided pursuant to an order by a physician in accordance with this article AND ARTICLES 5 AND 6 OF THIS TITLE, the executive director of the state department shall authorize reimbursement for said services. For the purposes of this section, "audiologist" or "speech pathologist" means an individual who meets the requirements set forth in the federal "Social Security Act", as amended, or any federal regulations adopted pursuant thereto, for participating providers of audiology or speech pathology services.

(2) Nothing in this section shall be construed as expanding the provision of services available as a part of the medical assistance ~~programs~~ PROGRAM established pursuant to this article AND ARTICLES 5 AND 6 OF THIS TITLE. For the purposes of making payments to audiologists or speech pathologists pursuant to this section, the state ~~department~~ BOARD shall establish rules ~~and regulations~~ implementing this section. The rules ~~and regulations~~ promulgated pursuant to this subsection (2) shall ensure that the costs to the medical assistance program will result in no increase in the total cost of the program solely as a result of the reimbursement for services of an audiologist or speech pathologist pursuant to this section.

(3) Payments for services included in this section shall be made directly to the audiologist or speech pathologist, if requested by the audiologist or speech pathologist; except that this section shall not apply to audiologists or speech pathologists when acting within the scope of their employment as salaried employees of public or private institutions or physicians.

25.5-4-411. [Formerly 26-4-414.3] Authorization of services provided by dental hygienists. (1) When dental hygiene services are provided to children by a licensed dental hygienist who is providing dental hygiene services pursuant to section 12-35-124, C.R.S., without the supervision of a licensed dentist, the executive director of the state department shall authorize reimbursement for said services, subject to the requirements of this section. Payment for such services shall be made directly to the licensed dental hygienist, if requested by the licensed dental hygienist; except that this section shall not apply to licensed dental hygienists when

acting within the scope of their employment as salaried employees of public or private institutions, physicians, or dentists.

(2) For each child provided dental hygiene services pursuant to this section, the dental hygienist shall attempt to identify a dentist participating in medicaid for the child.

25.5-4-412. [Formerly 26-4-414.5] Medical services provided by certified family planning clinics. (1) When medical or diagnostic services are provided in accordance with this article AND ARTICLES 5 AND 6 OF THIS TITLE by a certified family planning clinic, the executive director of the state department shall authorize reimbursement for the services. The reimbursement shall be made directly to the certified family planning clinic.

(2) For purposes of this section, "certified family planning clinic" means a family planning clinic certified by the Colorado department of public health and environment, accredited by a national family planning organization, and staffed by medical professionals licensed to practice in the state of Colorado, including, but not limited to, doctors of medicine, doctors of osteopathy, physicians' assistants, and advanced practice nurses.

(3) For purposes of this section, all medical care services or goods rendered by a certified family planning clinic that are benefits of the Colorado medical assistance program shall be ordered by a physician who need not be physically present on the premises of the certified family planning clinic at the time services are rendered.

(4) Nothing in this section shall be construed as expanding the provision of services available as a part of the medical assistance ~~programs~~ PROGRAM established pursuant to this article AND ARTICLES 5 AND 6 OF THIS TITLE. For purposes of making payments to certified family planning clinics pursuant to this section, the state ~~department~~ BOARD shall establish rules ~~and regulations~~ implementing this section. The rules ~~and regulations~~ promulgated pursuant to this subsection (4) shall ensure that the reimbursement for services rendered by a certified family planning clinic pursuant to this section shall not be the sole result of an increase in the costs to the state medical assistance program.

25.5-4-413. [Formerly 26-4-403.5] Certain providers to inform patients of rights concerning advance medical directives. (1) On and after November 5, 1991, with regard to any service rendered on and after said date, each hospital, nursing care facility, home health agency, hospice program, and health maintenance organization participating in the state medical assistance program or providing medical assistance pursuant to ~~part 6 of this article~~ PARTS 3 TO 12 OF ARTICLE 6 OF THIS TITLE shall provide written information to all adult patients of such providers concerning patients' rights under state law to make medical treatment decisions, including the right to accept or refuse any medical or surgical treatment and the right to formulate advance directives regarding said decisions. As used in this section, "advance directives" includes any written or oral instructions recognized under state law concerning the making of medical treatment decisions on behalf of or the provision of medical care for the person who provided the instructions in the event such person becomes incapacitated. Advance directives include, but are not

limited to, medical durable powers of attorney, durable powers of attorney, or living wills.

(2) Providers listed in subsection (1) of this section shall provide educational programs for staff and the community concerning advance directives and shall maintain written policies detailing methods for safeguarding patients' rights concerning medical treatment decisions, including documenting in the patient's medical or patient record whether the patient has executed, amended, or revoked an advance directive. No provider shall condition the provision of services or otherwise discriminate against a patient on the basis of whether the patient has executed an advance directive.

25.5-4-414. [Formerly 26-4-410.5] Providers - physicians - prohibition of certain referrals. (1) As used in this section, unless the context otherwise requires:

(a) "Designated health services" means any of the following services:

(I) Clinical laboratory services;

(II) Physical therapy services;

(III) Occupational therapy services;

(IV) Radiology and other diagnostic services;

(V) Radiation therapy services;

(VI) Durable medical equipment;

(VII) Parenteral or enteral nutrients, equipment, and supplies;

(VIII) Prosthetics, orthotics, and prosthetic devices;

(IX) Home health services;

(X) Outpatient prescription drugs; and

(XI) Inpatient and outpatient hospital services.

(b) "Financial relationship" means an ownership or investment interest in an entity furnishing designated health services or a compensation arrangement between a provider or an immediate family member of the provider and the entity. An ownership or investment interest may be reflected in equity, debt, or other instruments.

(c) "Immediate family member of the provider" means any spouse, natural or adoptive parent, natural or adoptive child, stepparent, stepchild, stepbrother, stepsister, in-law, grandparent, or grandchild of the provider.

(d) "Provider" means:

(I) A doctor of medicine or osteopathy who is licensed to practice medicine pursuant to article 36 of title 12, C.R.S.;

(II) A doctor of dental surgery or of dental medicine who is licensed to practice dentistry pursuant to article 35 of title 12, C.R.S.;

(III) A doctor of podiatric medicine who is licensed to practice podiatry pursuant to article 32 of title 12, C.R.S.;

(IV) A doctor of optometry who is licensed to practice optometry pursuant to article 40 of title 12, C.R.S.; or

(V) A chiropractor who is licensed to practice chiropractic pursuant to article 33 of title 12, C.R.S.

(2) (a) Except as otherwise provided in this subsection (2), a provider participating in the medical assistance program under this article AND ARTICLES 5 AND 6 OF THIS TITLE is prohibited from making a referral to an entity for designated health services for which payment may be made under the state's medical assistance program if the provider or an immediate family member of the provider has a financial relationship with the entity.

(b) Paragraph (a) of this subsection (2) shall not apply to any financial relationship that meets the requirements of an exception to the prohibitions established by 42 U.S.C. sec. 1395nn, as amended, or any regulations promulgated thereunder, as amended.

(c) Paragraph (a) of this subsection (2) shall not apply to a financial relationship or referral for designated health services if the financial relationship or referral for designated health services would not violate 42 U.S.C. sec. 1395nn, as amended, and any regulations promulgated thereunder, as amended, if the designated health services were eligible for payment under medicare rather than the "Colorado Medical Assistance Act".

(3) An entity that provides designated health services as a result of a prohibited referral shall not present a claim or bill to any individual, any third-party payor, the state department, or any other entity for the designated health services.

(4) An entity that provides designated health services shall provide to the state department, upon its request and in the form specified by the state department, information concerning the entity's ownership arrangements including:

(a) The items and services provided by the entity;

(b) The names and provider identification numbers of all providers with a financial interest in the entity or whose immediate family members have a financial interest in the entity.

(5) If a provider refers a patient for designated health services in violation of paragraph (a) of subsection (2) of this section or the entity refuses to provide the information required in subsection (4) of this section, the state department may:

- (a) Deny any claims for payment from the provider or entity;
- (b) Require the provider or entity to refund payments for services;
- (c) Refer the matter to the appropriate agency for medical assistance fraud investigation; or
- (d) Terminate the provider's or entity's participation in the medical assistance program.

25.5-4-415. [Formerly 26-4-512] No public funds for abortion - exception.

(1) It is the purpose of this section to implement the provisions of section 50 of article V of the Colorado constitution, adopted by the registered electors of the state of Colorado at the general election November 6, 1984, which prohibits the use of public funds by the state of Colorado or its agencies or political subdivisions to pay or otherwise reimburse, directly or indirectly, any person, agency, or facility for any induced abortion.

(2) If every reasonable effort has been made to preserve the lives of a pregnant woman and her unborn child, then public funds may be used pursuant to this section to pay or reimburse for necessary medical services, not otherwise provided for by law.

(3) (a) Except as provided in paragraph (b) of this subsection (3), any necessary medical services performed pursuant to this section shall be performed only in a licensed health care facility by a provider who is a licensed physician.

(b) However, such services may be performed in other than a licensed health care facility if, in the medical judgment of the attending physician, the life of the pregnant woman or her unborn child is substantially threatened and a transfer to a licensed health care facility would further endanger the life of the pregnant woman or her unborn child. Such medical services may be performed in other than a licensed health care facility if the medical services are necessitated by a life-endangering circumstance described in subparagraph (II) of paragraph (b) of subsection (6) of this section and if there is no licensed health care facility within a thirty-mile radius of the place where such medical services are performed.

(4) (a) Any physician who renders necessary medical services pursuant to subsection (2) of this section shall report the following information to the state department:

(I) The age of the pregnant woman and the gestational age of the unborn child at the time the necessary medical services were performed;

(II) The necessary medical services which were performed;

(III) The medical condition which necessitated the performance of necessary medical services;

(IV) The date such necessary medical services were performed and the name of the facility in which such services were performed.

(b) The information required to be reported pursuant to paragraph (a) of this subsection (4) shall be compiled by the state department and such compilation shall be an ongoing public record; except that the privacy of the pregnant woman and the attending physician shall be preserved.

(5) For purposes of this section, pregnancy is a medically diagnosable condition.

(6) For the purposes of this section:

(a) (I) "Death" means:

(A) The irreversible cessation of circulatory and respiratory functions; or

(B) The irreversible cessation of all functions of the entire brain, including the brain stem.

(II) A determination of death under this section shall be in accordance with accepted medical standards.

(b) "Life-endangering circumstance" means:

(I) The presence of a medical condition, other than a psychiatric condition, as determined by the attending physician, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term;

(II) The presence of a lethal medical condition in the unborn child, as determined by the attending physician and one other physician, which would result in the impending death of the unborn child during the term of pregnancy or at birth; or

(III) The presence of a psychiatric condition which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term. In such case, unless the pregnant woman has been receiving prolonged psychiatric care, the attending licensed physician shall obtain consultation from a licensed physician specializing in psychiatry confirming the presence of such a psychiatric condition. The attending physician shall report the findings of such consultation to the state department.

(c) "Necessary medical services" means any medical procedures deemed necessary to prevent the death of a pregnant woman or her unborn child due to life-endangering circumstances.

(7) If any provision of this section or application thereof is held invalid, such invalidity shall not affect other provisions or applications of this section which can be given effect without the invalid provision or application, and to this end the provisions of this section are declared severable.

(8) Use of the term "unborn child" in this section is solely for the purposes of facilitating the implementation of section 50 of article V of the state constitution, and its use shall not affect any other law or statute nor shall it create any presumptions relating to the legal status of an unborn child or create or affect any distinction between the legal status of an unborn child and the legal status of a fetus.

(9) This section shall be repealed if section 50 of article V of the Colorado constitution is repealed.

PART 5
STATE PLAN AMENDMENTS -
WAIVER AUTHORITY

25.5-4-501. [Formerly 26-4-105.8] State plan amendment - federal authorization - repeal. (1) The state department shall amend the state plan for medical assistance or seek the necessary federal authorization to reflect the addition of sections ~~26-4-201 (4) and 26-4-301 (1) (t) and (9)~~ 25.5-5-101 (4) AND 25.5-5-201 (1) (l) AND (5).

(2) The state department shall amend the state's existing waivers for the children's extensive support program and the children's home- and community-based service program, authorized by section ~~26-4-509~~ 25.5-6-901, to increase the number of children authorized to be enrolled in the programs to equal the number of children enrolled in each program on July 1, 2005, plus the number of children on the waiting list for each program as of January 1, 2005.

(3) This section is repealed, effective July 1, 2007.

25.5-4-502. [Formerly 25.5-1-113] Federal authorization - repeal. (1) As used in this section, unless the context otherwise requires:

(a) "Eligible person" means a person who is eligible to receive services under ~~part 6 of article 4 of title 26, C.R.S., PARTS 3 TO 12 OF ARTICLE 6 OF THIS TITLE~~ or any other home- and community-based service waiver for which the state department has federal waiver authority.

(b) "Qualified services" means services provided under the eligible person's applicable waiver program and attendant support.

(2) The state department shall amend the necessary waivers to allow an eligible person to receive qualified services through the consumer-directed care service model.

(3) This section is repealed, effective July 1, 2007.

25.5-4-503. [Formerly 25.5-1-111] Waiver applications - authorization. The state department is authorized to apply for health insurance flexibility and accountability waivers that will enable the state to add more flexibility to Colorado's medicaid program and that will result in a cost-effective method of providing health care services to Coloradans.

ARTICLE 5
Colorado Medical Assistance Act

PART 1
MANDATORY PROVISIONS

25.5-5-101. [Formerly 26-4-201] Mandatory provisions - eligible groups - repeal. (1) In order to participate in the medicaid program, the federal government requires the state to provide medical assistance to certain eligible groups. Pursuant to federal law and except as provided in subsection (2) of this section, any person who is eligible for medical assistance under the mandated groups specified in this section shall receive both the mandatory services that are specified in sections ~~26-4-202 and 26-4-203~~ 25.5-5-102 AND 25.5-5-103 and the optional services that are specified in sections ~~26-4-302 and 26-4-303~~ 25.5-5-202 AND 25.5-5-203. Subject to the availability of federal financial ~~aid funds~~ PARTICIPATION, the following are the individuals or groups that are mandated under federal law to receive benefits under this article AND ARTICLES 4 AND 6 OF THIS TITLE:

(a) Individuals who meet the eligibility criteria for the aid to families with dependent children program pursuant to rules that were in effect on July 16, 1996;

(b) Families who meet the eligibility criteria for the aid to families with dependent children program established in rules that were in effect on July 16, 1996, and who subsequently would have become ineligible under such eligibility criteria because of increased earnings or increased hours of employment whose eligibility is specified for a period of time by the federal government;

~~(c) to (c) (Deleted by amendment, L. 97, p. 1237, § 28, effective July 1, 1997.)~~

~~(f)~~ (c) Qualified pregnant women, and children under the age of seven, who meet the income requirements of the state's aid to families with dependent children program pursuant to rules that were in effect on July 16, 1996;

~~(g)~~ (d) A newborn child born of a woman who is categorically needy. Such child is deemed medicaid-eligible on the date of birth and remains eligible for one year so long as the woman remains categorically needy and the child is a member of her household.

~~(h)~~ (e) Children for whom adoption assistance or foster care maintenance payments are made under Title IV-E of the "Social Security Act", as amended;

~~(i)~~ (f) Individuals receiving supplemental security income;

~~(j)~~ (g) Individuals receiving mandatory state supplement, including but not limited to individuals receiving old age pensions;

~~(k)~~ (h) Institutionalized individuals who were eligible for medical assistance in December, 1973;

~~(l)~~ (i) Individuals who would be eligible except for the increase in old-age, survivors, and disability insurance under P.L. 92-336;

~~(m)~~ (j) Individuals who become ineligible for cash assistance as a result of old-age, survivors, and disability insurance cost-of-living increases after April, 1977;

~~(n.5)~~ (k) Disabled widows or widowers fifty through sixty years of age who have

become ineligible for federal supplemental security income or state supplementation as a result of becoming eligible for federal social security survivor's benefits, in accordance with the social security act, 42 U.S.C. sec. 1383c;

~~(m)~~ (l) Individuals with income and resources at a level which qualifies them as medicare-eligible under section 301 of Title III of the federal "Medicare Catastrophic Coverage Act";

~~(n)~~ (m) Low-income pregnant women, and children through the age of six, whose income is at or below a certain percentage of the federal poverty level as determined by the federal government.

~~(p) (Deleted by amendment, L. 97, p. 1237, § 28, effective July 1, 1997.)~~

(2) (a) A qualified alien who entered the United States before August 22, 1996, who meets the exceptions described in the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193, as amended, shall receive benefits under this article AND ARTICLES 4 AND 6 OF THIS TITLE.

(b) A qualified alien who entered the United States on or after August 22, 1996, shall not be eligible for benefits under this article OR ARTICLE 4 OR 6 OF THIS TITLE, except as provided in section ~~26-4-203 (3)~~ 25.5-5-103 (3), for five years after the date of entry into the United States unless he or she meets the exceptions described in the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193, as amended.

(3) Notwithstanding any other provision of this article AND ARTICLES 4 AND 6 OF THIS TITLE, as a condition of eligibility for medical assistance under this article AND ARTICLES 4 AND 6 OF THIS TITLE, a legal immigrant shall agree to refrain from executing an affidavit of support for the purpose of sponsoring an alien on or after July 1, 1997, under rules promulgated by the immigration and naturalization service during the pendency of such legal immigrant's receipt of medical assistance. Nothing in this subsection (3) shall be construed to affect a legal immigrant's eligibility for medical assistance under this article AND ARTICLES 4 AND 6 OF THIS TITLE based upon such legal immigrant's responsibilities under an affidavit of support entered into before July 1, 1997.

(4) (a) An asset test shall not be applied as a condition of eligibility for individuals or families described in paragraphs (a), (b), and ~~(c)~~ (c) of subsection (1) of this section.

(b) (I) The state department is authorized to seek any necessary federal approval to allow a child eligible to receive benefits under article ~~19~~ 8 of this title, who, because of the enactment of this subsection (4), becomes eligible to receive benefits under this article AND ARTICLES 4 AND 6 OF THIS TITLE, to continue to receive benefits under article ~~19~~ 8 of this title to assure patient continuity of care and provider network stabilization provided that those benefits may not continue after July 1, 2006. The state department is authorized to implement this provision consistent with the federal authorization.

(II) This paragraph (b) is repealed, effective July 1, 2007.

25.5-5-102. [Formerly 26-4-202] Basic services for the categorically needy - mandated services. (1) Subject to the provisions of subsection (2) of this section and section ~~26-4-104~~ 25.5-4-104, the program for the categorically needy shall include the following services as mandated and defined by federal law:

- (a) Inpatient hospital services;
- (b) Outpatient hospital services;
- (c) Other laboratory and X-ray services;
- (d) Physicians' services, wherever furnished;
- (e) Nursing facility services;
- (f) Home health services;
- (g) Early AND periodic screening, ~~and~~ diagnosis, and treatment, as required by federal law;
- (h) Family planning;
- (i) Rural health services;
- (j) Nurse-midwife services;
- (k) Pediatric nurse practitioner services;
- (l) Family nurse practitioner services;
- (m) Federally qualified health centers.

(2) In order to keep expenditures within approved appropriations, the ~~medical services~~ STATE board may, by rule, establish limits on a service provided pursuant to this section so long as the service provided is sufficient in the amount, duration, and scope to reasonably achieve the purpose of the service as required by federal law or regulation. When a rule is promulgated pursuant to this subsection (2), the ~~medical services~~ STATE board shall provide a summary report of the limitations established by the rule and any fiscal impact of the rule to members of the ~~health, environment, welfare, and institutions~~ HEALTH AND HUMAN SERVICES committees of the senate and house of representatives, OR ANY SUCCESSOR COMMITTEES, and any other members of the general assembly who request the reports.

25.5-5-103. [Formerly 26-4-203] Mandated programs with special state provisions. (1) This section specifies programs developed by Colorado to meet federal mandates. These programs include but are not limited to:

- (a) The program known as the baby and kid care program which provides medical assistance for pregnant women and children, as specified in section ~~26-4-508~~ 25.5-5-205;

(b) Special provisions relating to nursing facilities, as specified in sections ~~26-4-502 to 26-4-505~~ 25.5-6-201 TO 25.5-6-203, 25.5-6-205, AND 25.5-6-206;

(c) The program for qualified medicare beneficiaries, as specified in section ~~26-4-510~~ 25.5-5-104;

(d) The program for qualified disabled and working individuals, as specified in section ~~26-4-511~~ 25.5-5-105;

(e) Special provisions for the purchase of group health insurance for recipients, as specified in section ~~26-4-518.5~~ 25.5-4-210;

(f) The program to provide health services to students by school districts as specified in section ~~26-4-531~~ 25.5-5-318.

(2) The medical assistance program also is subject to special provisions relating to the use of public funds for abortion which are required by section 50 of article V of the Colorado constitution. Those special provisions are specified in section ~~26-4-512~~ 25.5-4-415.

(3) (a) Emergency medical assistance shall be provided to any person who is not a citizen of the United States, including undocumented aliens, aliens who are not qualified aliens, and qualified aliens who entered the United States on or after August 22, 1996, who has an emergency medical condition and meets one of the categorical requirements set forth in section ~~26-4-201~~ 25.5-5-101; except that such persons shall not be required to meet any residency requirement other than that required by federal law.

~~(a.5) and (a.6) Repealed.~~

(b) The ~~medical services~~ STATE board shall adopt rules necessary for the implementation of this subsection (3), including in such rules definitions of "emergency services", "emergency medical condition", "geographic area", and "prenatal care".

~~(c) Repealed.~~

25.5-5-104. [Formerly 26-4-510] Qualified medicare beneficiaries. Qualified medicare beneficiaries are medicare-eligible individuals with income and resources at a level which qualifies them as eligible under section 301 of Title III of the federal "Medicare Catastrophic Coverage Act of 1988", as amended, or subsequent amending federal legislation. For purposes of this article AND ARTICLES 4 AND 6 OF THIS TITLE, such individuals shall be referred to as "qualified medicare beneficiaries". The state department is hereby designated as the single state agency to administer benefits available to qualified medicare beneficiaries in accordance with Title XIX and this article AND ARTICLES 4 AND 6 OF THIS TITLE. Such benefits are limited to medicare cost-sharing expenses as determined by the federal government. Accordingly, the state department shall not be required to provide qualified medicare beneficiaries the entire range of services set forth in section ~~26-4-202~~ 25.5-5-102.

25.5-5-105. [Formerly 26-4-511] Qualified disabled and working individuals. Qualified disabled and working individuals are persons with income and resources and disability status, as determined by the social security administration, which qualify them as "qualified disabled and working individuals" under sections 6012 and 6408 of the federal "Omnibus Budget Reconciliation Act of 1989", or subsequent amending federal legislation. The state department is hereby designated as the single state agency to administer benefits available to qualified disabled and working individuals. Such benefits are limited to medicare cost-sharing expenses as determined by the federal government. Accordingly, the state department shall not be required to provide qualified disabled and working individuals the entire range of services set forth in section ~~26-4-202~~ 25.5-5-102.

PART 2 OPTIONAL PROVISIONS

25.5-5-201. [Formerly 26-4-301] Optional provisions - optional groups - repeal. (1) The federal government allows the state to select optional groups to receive medical assistance. Pursuant to federal law, any person who is eligible for medical assistance under the optional groups specified in this section shall receive both the mandatory services specified in sections ~~26-4-202 and 26-4-203~~ 25.5-5-102 AND 25.5-5-103 and the optional services specified in sections ~~26-4-302 and 26-4-303~~ 25.5-5-202 AND 25.5-5-203. Subject to the availability of federal financial aid funds, the following are the individuals or groups that Colorado has selected as optional groups to receive medical assistance pursuant to this article AND ARTICLES 4 AND 6 OF THIS TITLE:

- (a) Individuals who would be eligible for but are not receiving cash assistance;
- (b) Individuals who would be eligible for cash assistance except for their institutionalized status;
- (c) Individuals receiving home- and community-based services as specified in ~~part 6 of this article~~ ARTICLE 6 OF THIS TITLE;
- (d) Individuals who would be eligible for aid to families with dependent children if child care were paid from earnings;
- (e) Individuals under the age of twenty-one who would be eligible for aid to families with dependent children but do not qualify as dependent children;
- (f) Individuals receiving only optional state supplement;
- (g) Individuals in institutions who are eligible under a special income level. Colorado's program for citizens sixty-five years of age or older or physically disabled or blind, whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, qualifies for federal funding under this provision.
- ~~(h) Repealed.~~
- ~~(i) Individuals who are sentenced to the custody of the executive director of the~~

~~department of corrections and are confined in a state correctional facility as set forth in section 26-4-530;~~

~~(j) Infants born to females who are in the custody of the executive director of the department of corrections as set forth in section 26-4-530;~~

~~(k) to (m) Repealed.~~

~~(n) Individuals transitioning between public assistance and self-sufficiency in the buy-in program established in section 26-4-110.5;~~

~~(o)~~ (h) Persons who are eligible for cash assistance under the works program pursuant to section 26-2-706, C.R.S.;

~~(p) Individuals with disabilities who are participating in the medicaid buy-in program established in part 12 of this article;~~

~~(q)~~ (i) PERSONS WHO ARE ELIGIBLE FOR the breast and cervical cancer prevention and treatment program pursuant to section ~~26-4-532~~ 25.5-5-308;

~~(r)~~ (j) Individuals who are qualified aliens and were or would have been eligible for supplemental security income as a result of a disability but are not eligible for such supplemental security income as a result of the passage of the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193;

~~(s)~~ (k) Other qualified aliens who entered or were present in the United States before August 22, 1996;

~~(t)~~ (l) Children for whom subsidized adoption assistance payments are made by the state pursuant to article 7 of this title 26, C.R.S., but who do not meet the requirements of Title IV-E of the "Social Security Act", as amended;

~~(u)~~ (m) (I) Parents of children who are eligible for the medical assistance program or the children's basic health plan, article ~~19~~ 8 of this title, whose family income does not exceed a specified percent of the federal poverty level, adjusted for family size, as set by the state board by rule, which percentage shall be not less than sixty percent.

(II) (A) The provisions of subparagraph (I) of this paragraph ~~(u)~~ (m) shall take effect on July 1, 2006; except that the department may delay the effective date of subparagraph (I) of this paragraph ~~(u)~~ (m) to not later than January 1, 2007, if necessary to fulfill the conditions of implementing an approved federal waiver to expand eligibility to parents and deliver streamlined health care to families and children. To delay the effective date, the department shall notify the revisor of statutes of such fact on or before May 1, 2006, and, once the delay is no longer needed, the department shall promptly notify the revisor of statutes of such fact.

(B) This subparagraph (II) is repealed, effective January 1, 2007.

~~(2) to (4) Repealed.~~

~~(5) (Deleted by amendment, L. 2005, p. 1, § 1, effective January 1, 2005.)~~

~~(6)~~ (2) A qualified alien, who entered the United States on or after August 22, 1996, shall not be eligible for benefits under this article AND ARTICLES 4 AND 6 OF THIS TITLE, except as provided in section ~~26-4-203 (3)~~ 25.5-5-103 (3), for five years after the date of entry into the United States unless he or she meets the exceptions described in the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193, as amended. After five years, such qualified alien shall be eligible for benefits under this article AND ARTICLES 4 AND 6 OF THIS TITLE but shall have sponsor income and resources deemed to the individual or family under rules established by the state board OF HUMAN SERVICES pursuant to section 26-2-137, C.R.S.

~~(7)~~ (3) A legal immigrant who is receiving medicaid nursing facility care or home- and community-based services on July 1, 1997, shall continue to receive such services as long as he or she meets the eligibility requirements other than citizen status. State general funds may be used to reimburse such care in the event that federal financial participation is not available.

~~(8)~~ (4) A pregnant legal immigrant shall be eligible to receive prenatal and medical services for labor and delivery as long as she meets eligibility requirements other than citizen status. State general funds may be used to reimburse such care in the event that federal financial participation is not available.

~~(9)~~ (5) (a) An asset test shall not be applied as a condition of eligibility for individuals or families described in paragraphs (a), ~~(b)~~ (h), and ~~(c)~~ (m) of subsection (1) of this section.

(b) (I) The state department is authorized to seek any necessary federal approval to allow a child eligible to receive benefits under article ~~19~~ 8 of this title, who, because of the enactment of this subsection ~~(9)~~ (5), becomes eligible to receive benefits under this article AND ARTICLES 4 AND 6 OF THIS TITLE, to continue to receive benefits under article ~~19~~ 8 of this title to assure patient continuity of care and provider network stabilization provided that those benefits may not continue after July 1, 2006. The state department is authorized to implement this provision consistent with the federal authorization.

(II) This paragraph (b) is repealed, effective July 1, 2007.

25.5-5-202. [Formerly 26-4-302] Basic services for the categorically needy - optional services - repeal. (1) Subject to the provisions of subsection (2) of this section, the following are services for which federal financial participation is available and which Colorado has selected to provide as optional services under the medical assistance program:

(a) (I) Prescribed drugs.

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (a), pursuant to the provisions of section ~~26-4-406.5~~ 25.5-5-503, prescribed drugs shall not be a covered benefit under the medical assistance program for a recipient who is enrolled in a prescription drug benefit program under medicare; except that, if a

prescribed drug is not a covered Part D drug as defined in the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003", P.L. 108-173, the prescribed drug may be a covered benefit if it is otherwise covered under the medical assistance program and federal financial participation is available.

(b) Clinic services, as defined in sections ~~26-4-513 and 26-4-514~~ 25.5-5-301 AND 25.5-5-302;

(c) Home- and community-based services, as specified in ~~part 6 of this article 6~~ OF THIS TITLE, which include:

(I) Home- and community-based services for elderly, blind, and disabled persons, as specified in ~~subpart 1 of part 6 of this article~~ PART 3 OF ARTICLE 6 OF THIS TITLE;

(II) Home- and community-based services for developmentally disabled persons, as specified in ~~subpart 2 of part 6 of this article~~ PART 4 OF ARTICLE 6 OF THIS TITLE;

(III) Home- and community-based services for persons living with AIDS, as specified in ~~subpart 3 of part 6 of this article~~ PART 5 OF ARTICLE 6 OF THIS TITLE;

(IV) Home- and community-based services for persons with major mental illnesses, as specified in ~~subpart 5 of part 6 of this article~~ PART 6 OF ARTICLE 6 OF THIS TITLE;

(V) Home- and community-based services for persons with brain injury, as specified in ~~subpart 6 of part 6 of this article~~ PART 7 OF ARTICLE 6 OF THIS TITLE;

(d) Optometrist services;

(e) Eyeglasses when necessary after surgery;

(f) Prosthetic devices, including medically necessary augmentative communication devices; except that nonsurgically implanted prosthetic devices shall be included only after July 1, 1998, and only if the general assembly approves appropriations for these devices as a new benefit;

(g) Rehabilitation services as appropriate to community mental health centers;

~~(h) (Deleted by amendment, L. 2004, p. 264, § 1, effective July 1, 2004.)~~

~~(i)~~ (h) Intermediate care facilities for the mentally retarded;

~~(j)~~ (i) Inpatient psychiatric services for persons under twenty-one years of age;

~~(k)~~ (j) Inpatient psychiatric services for persons over the age of sixty-five;

~~(l)~~ (k) Case management;

~~(m)~~ (l) Therapies under home health services, including:

(I) Speech and audiology;

(II) Physical;

(III) Occupational;

~~(m)~~ (m) Services of a licensed psychologist;

~~(n)~~ (n) Private duty nursing services;

~~(o)~~ (o) Podiatry services;

~~(p)~~ (p) Hospice care;

~~(q)~~ (q) The program of all-inclusive care for the elderly;

~~(r)~~ ~~(t)~~ (r) For any pregnant woman who is enrolled for services pursuant to section ~~26-4-508~~ 25.5-5-205, or who would be eligible for aid to families with dependent children pursuant to rules in effect on July 16, 1996, alcohol and drug and addiction counseling and treatment, including outpatient and residential care but not including room and board while receiving residential care.

~~(H)~~ (Deleted by amendment, L. 94, p. 696, § 5, effective April 19, 1994.)

~~(t)~~ Repealed.

~~(u)~~ (s) (I) Outpatient substance abuse treatment.

(II) On or before March 31, 2011, pursuant to section ~~26-4-536 (2)~~ 25.5-5-313 (2), if the legislative audit committee adopts a resolution finding that providing outpatient substance abuse treatment has resulted in an overall increase in costs to the medical assistance program, this paragraph ~~(u)~~ (s) is repealed, effective July 1, 2011.

~~(1.5)~~ (2) In addition to the services described in subsection (1) of this section and subject to continued federal financial participation, Colorado has selected to provide transportation services as an administrative cost.

~~(2)~~ (3) In order to keep expenditures within approved appropriations, the ~~medical services~~ STATE board may, by rule, establish limits on a service provided pursuant to this section so long as the service provided is sufficient in the amount, duration, and scope to reasonably achieve the purpose of the service as required by federal law or regulation. When a rule is promulgated pursuant to this subsection ~~(2)~~ (3), the ~~medical services~~ STATE board shall provide a summary report of the limitations established by the rule and any fiscal impact of the rule to members of the ~~health, environment, welfare, and institutions~~ HEALTH AND HUMAN SERVICES committees of the senate and house of representatives, OR ANY SUCCESSOR COMMITTEES, and any other members of the general assembly who request the reports.

25.5-5-203. [Formerly 26-4-303] Optional programs with special state provisions. (1) Subject to the provisions of subsection (2) of this section, this section specifies programs developed by Colorado to increase federal financial participation through selecting optional services or optional eligible groups. These

programs include but are not limited to:

- (a) Pharmaceutical services, as specified in section ~~26-4-407~~ 25.5-5-504;
- (b) The home- and community-based services program for the elderly, blind, and disabled, as specified in ~~subpart 1 of part 6 of this article~~ PART 3 OF ARTICLE 6 OF THIS TITLE;
- (c) The home- and community-based services program for the developmentally disabled, as specified in ~~subpart 2 of part 6 of this article~~ PART 4 OF ARTICLE 6 OF THIS TITLE;
- (d) The home- and community-based services program for persons living with AIDS, as specified in ~~subpart 3 of part 6 of this article~~ PART 5 OF ARTICLE 6 OF THIS TITLE;
- ~~(d.5)~~ (e) The home- and community-based services program for persons with major mental illnesses, as specified in ~~subpart 5 of part 6 of this article~~ PART 6 OF ARTICLE 6 OF THIS TITLE;
- ~~(d.7)~~ (f) The home- and community-based services program for persons with brain injury, as specified in ~~subpart 6 of part 6 of this article~~ PART 7 OF ARTICLE 6 OF THIS TITLE;
- ~~(e)~~ (g) Clinic services, as defined in sections ~~26-4-513 and 26-4-514~~ 25.5-5-301 AND 25.5-5-302;
- ~~(f)~~ (h) The program for private duty nursing, as specified in section ~~26-4-517~~ 25.5-5-303;
- ~~(g)~~ (i) The disabled children care program, as specified in section ~~26-4-509~~ 25.5-6-901;
- ~~(h)~~ (j) The program of all-inclusive care for the elderly, as specified in section ~~26-4-124~~ 25.5-5-412;
- ~~(i)~~ (k) Hospice care, as specified in section ~~26-4-520~~ 25.5-5-304;
- ~~(j)~~ (l) The treatment program for high-risk pregnant women, as specified in section 25-1-212, C.R.S., and sections ~~26-4-508.2, 26-4-508.3, 26-4-508.4, and 26-4-508.5~~ 25.5-5-309, 25.5-5-310, AND 25.5-5-311;
- ~~(k)~~ (m) The program for residential child health care, as specified in section ~~26-4-527~~ 25.5-5-306;
- ~~(l)~~ Repealed:
- ~~(m)~~ (n) The children's personal assistance services and family support waiver program, as specified in section ~~26-4-509.2~~ 25.5-6-902;
- ~~(n)~~ (o) Home- and community-based services for children with autism, as

specified in ~~subpart 7 of part 6 of this article~~ PART 8 OF ARTICLE 6 OF THIS TITLE.

(2) In order to keep expenditures within approved appropriations, the ~~medical services~~ STATE board may, by rule, establish limits on a service provided pursuant to this section so long as the service provided is sufficient in the amount, duration, and scope to reasonably achieve the purpose of the service as required by federal law or regulation. When a rule is promulgated pursuant to this subsection (2), the ~~medical services~~ STATE board shall provide a summary report of the limitations established by the rule and any fiscal impact of the rule to members of the ~~health, environment, welfare, and institutions~~ HEALTH AND HUMAN SERVICES committees of the senate and house of representatives, OR ANY SUCCESSOR COMMITTEES, and any other members of the general assembly who request the reports.

25.5-5-204. [Formerly 26-4-304] Presumptive eligibility - pregnant women - state plan. (1) For purposes of this section, "presumptive eligibility" means the self-declaration of income, assets, and status in order to promptly receive medical assistance services prior to the verification of income, assets, and status.

(2) (a) A pregnant woman shall be presumptively eligible for the medical assistance program and shall receive services specified by federal law only if the woman declares all pertinent information relating to the criteria of income, assets, and status.

(b) A woman shall declare her immigration status unless the general assembly provides funding for prenatal care services for undocumented residents.

(3) The state department shall make any necessary changes to the state plan to comply with this section.

25.5-5-205. [Formerly 26-4-508] Baby and kid care program - creation - eligibility. (1) The general assembly hereby finds and declares that the health and well-being of the children of Colorado are at risk; that access to prenatal care by pregnant women in Colorado is inadequate; that lack of access to prenatal care results in a high rate of low-weight births; that children born with low weight are more likely to develop health problems during their lifetimes; that providing such essential care during pregnancy and early childhood would reduce the number of children with such health problems; that providing such care would not only benefit such children but would also benefit the citizens of Colorado by ensuring the present and future health of society and reducing the amount of state resources needed for such purposes; and that a significant need exists in Colorado for a program which utilizes medicaid funds to promote and provide such prenatal care and well child care.

(2) There is hereby created the baby and kid care program to promote and provide prenatal care and well child care to individuals who need such care but are currently unable to obtain it.

(3) (a) On and after April 1, 1990, children under the age of six years and pregnant women shall be eligible for benefits under the baby and kid care program; except that, for the purpose of eligibility under this subsection (3) only:

(I) Such individual's family income shall exceed the eligibility threshold used in determining eligibility for aid to families with dependent children assistance pursuant to rules in effect on July 16, 1996, but shall not exceed the equivalent of the percentage level of the federal poverty line that is specified pursuant to paragraph (b) of this subsection (3);

(II) (A) Except as otherwise provided in sub-subparagraph (B) of this subparagraph (II), children under six years of age shall meet the income standard used to determine eligibility for aid to families with dependent children assistance except as provided in this subsection (3).

(B) Pregnant women shall meet the income standard used to determine eligibility for aid to families with dependent children assistance except as provided in this subsection (3). No resource standard shall be applied to pregnant women as a condition of eligibility. Once initial eligibility has been established for a pregnant woman under this subsection (3), she shall be considered to be continuously eligible throughout the pregnancy and for the sixty days following the pregnancy, even if the woman's eligibility would otherwise terminate during such period due to an increase in income. A child born to a woman eligible for assistance pursuant to this subsection (3) shall be eligible for medical assistance until the child attains one year of age so long as the infant remains in the eligible woman's household and the woman would be eligible for assistance if she were pregnant.

(b) The percentage level of the federal poverty line, as defined pursuant to 42 U.S.C. sec. 9902 (2), used to determine eligibility under this subsection (3) shall be one hundred thirty-three percent. If the federal government establishes a new federal minimum percentage level of the federal poverty line used to determine eligibility under this subsection (3) that is different from the level set in this paragraph (b), the state department is authorized to meet such federal minimum level without requiring additional legislation; however, such minimum federal level shall be established by rule ~~and regulation by~~ OF the ~~medical services~~ STATE board.

(c) (I) On and after July 1, 1991, children born after September 30, 1983, who have attained age six but have not attained age nineteen shall be eligible for benefits under the baby and kid care program; except that, for the purpose of eligibility under this paragraph (c) only, such individual's family income shall exceed the eligibility threshold used in determining eligibility for aid to families with dependent children assistance pursuant to rules in effect on July 16, 1996, but shall not exceed the equivalent of the percentage level of the federal poverty line that is specified pursuant to subparagraph (II) of this paragraph (c).

(II) The percentage level of the federal poverty line, as defined pursuant to 42 U.S.C. sec. 9902 (2), used to determine eligibility under this paragraph (c) shall be one hundred percent. If the federal government establishes a new federal minimum percentage level of the federal poverty line used to determine eligibility under this paragraph (c) that is different from the level set in this subparagraph (II), the state department is authorized to meet such federal minimum level without requiring additional legislation; however, such minimum federal level shall be established by rule ~~and regulation by~~ OF the ~~medical services~~ STATE board.

(d) An asset test shall not be applied as a condition of eligibility for a child under

this subsection (3).

PART 3
SERVICES WITH SPECIAL STATE PROVISIONS

25.5-5-301. [Formerly 26-4-513] Clinic services. (1) As used in this article AND ARTICLES 4 AND 6 OF THIS TITLE, unless the context otherwise requires, "clinic services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to outpatients.

(2) Under the federal option for clinic services, Colorado has selected clinic services provided by the following:

- (a) Community mental health centers or clinics;
- (b) Community centered boards;
- (c) Birthing centers;
- (d) Ambulatory surgery facilities;
- (e) Freestanding dialysis clinics.

(3) "Clinic services" also means preventive, therapeutic, or palliative items or services that are furnished to patients by county or regional health departments or local boards of health established pursuant to part 5, 6, or 7 of article 1 of title 25, C.R.S., that are recommended for certification by the department of public health and environment as qualified to receive payments pursuant to this article AND ARTICLES 4 AND 6 OF THIS TITLE.

(4) "Clinic services" also means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that are furnished to a pregnant woman who is enrolled for services pursuant to section ~~26-4-508~~ 25.5-5-205 or who is eligible for aid to families with dependent children pursuant to rules in effect on July 16, 1996, in a facility which is not a part of a hospital but is organized and operated as a freestanding alcohol or drug treatment program approved and ~~certified~~ LICENSED by the division of alcohol and drug abuse of the department of human services pursuant to section 25-1-207 (1) (c), C.R.S.

(5) ~~(a)~~ "Clinic services" also means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that are furnished to children up to age twenty-one or to high-risk pregnant women in a facility which is not a part of a hospital but is organized and operated as a school-based clinic.

~~(b) The department of health care policy and financing shall submit a report to the education committees of the house of representatives and the senate on or before October 1, 2002, on the actual costs of implementing the increase in the number of school-based clinics serving children under the medical assistance program as a result of the passage of S.B. 00-020. The report shall compare the actual costs of implementing the bill for fiscal years 2000-01 and 2001-02 with the projected costs for fiscal years 2000-01 and 2001-02.~~

(6) "Clinic services" also means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that are furnished to students by a school district, board of cooperative services, or state educational institution within the scope of the "Colorado Medical Assistance Act" pursuant to the provisions of section ~~26-4-531~~ 25.5-5-318.

25.5-5-302. [Formerly 26-4-514] Clinic services - children and pregnant women - utilization of certain providers. (1) The state department shall utilize, to the extent possible and appropriate, county or regional health departments or local boards of health established pursuant to part 5, 6, or 7 of article 1 of title 25, C.R.S., that are certified by the department of public health and environment as qualified to receive payments pursuant to this article AND ARTICLES 4 AND 6 OF THIS TITLE, and that meet the requirements and standards set forth in rules ~~and regulations promulgated by the medical services~~ STATE board in the STATE department of health care policy and financing pursuant to section ~~26-4-104~~ 25.5-4-104 to provide clinic services to patients who are children under age seven or patients who are pregnant women.

(2) In complying with the provisions of subsection (1) of this section, the state department shall utilize, to the extent possible and appropriate, the health departments and boards of health specified in subsection (1) of this section to provide outreach to eligible pregnant women and children and to provide clinic services:

(a) Upon the referral of any physician; or

(b) When there exists no primary care physician who agrees to provide clinic services to such patients.

25.5-5-303. [Formerly 26-4-517] Private-duty nursing. (1) The medical assistance program in this state shall include ~~medicaid services for~~ private-duty nursing to persons who are technology dependent and otherwise eligible as provided under this section.

(2) A recipient is eligible for private-duty nursing services if he or she:

(a) Is dependent on technology at least part of each day;

(b) Requires private-duty nursing care as determined in accordance with state department rules;

(c) Is able to be served safely under the limitations of the private-duty nursing benefit and within the availability of services; and

(d) Is not residing in a nursing facility or hospital at the time of the delivery of the private-duty nursing services.

(3) (a) The state ~~department~~ BOARD shall establish rules in accordance with this section that identify medical criteria for determining the circumstances under which private-duty nursing services will be delivered to assure that only persons who need the services receive them and only to the extent medically necessary.

(b) Private-duty nursing services shall not be provided as twenty-four-hour care except in special circumstances and for limited time periods as established by the state department pursuant to this section.

(c) The home health agency, in conjunction with the family or in-home caregiver and the attending physician, shall include in a care plan that includes private-duty nursing services a process by which the eligible person may receive necessary care, which may include respite care, if the family or in-home caregiver is unavailable due to an emergency situation or to unforeseen circumstances. The family or in-home caregiver shall be duly informed by the home health agency of these alternative care provisions at the time the care plan is initiated.

(4) As used in this section, unless the context otherwise requires, "private-duty nursing" means nursing care that is more individualized and continuous than both the nursing care available under the home health benefit and the nursing care routinely provided in a hospital or nursing facility.

25.5-5-304. [Formerly 26-4-520] Hospice care. (1) The medical assistance program in this state shall include hospice care. Except as otherwise provided in subsection (2) of this section, hospice care shall be provided for a period of up to two hundred ten days in accordance with rules ~~and regulations~~ adopted by the ~~medical services~~ STATE board, which rules ~~and regulations~~ shall comply with section 1905 of the social security act, 42 U.S.C. sec. 1396d, and shall include at least the following requirements:

(a) That a person shall obtain a certified medical prognosis indicating a life expectancy of six months or less, which certification shall comply with rules ~~and regulations~~ adopted by the ~~medical services~~ STATE board;

(b) That a person shall execute a waiver of other medical benefits available under this article AND ARTICLES 4 AND 6 OF THIS TITLE, which election shall be executed in accordance with rules ~~and regulations~~ adopted by the ~~medical services~~ STATE board;

(c) That the service shall be reasonable and necessary for the palliation or management of the terminal illness and related conditions.

(2) Hospice care may be provided to a person beyond two hundred ten days if such person is recertified by a physician or hospice medical director as terminally ill in accordance with subsection (1) of this section.

25.5-5-305. [Formerly 26-4-533] Pediatric hospice care - legislative declaration - federal authorization - rules - fund - repeal. (1) **Legislative declaration.** (a) The general assembly finds and declares that:

(I) The death of a child has a devastating and enduring impact on the child's family;

(II) Too often, children with fatal conditions and their families fail to receive compassionate and consistent care that meets their physical, emotional, and spiritual needs;

(III) Better care is possible but current methods of organizing and financing palliative, end-of-life, and bereavement care impede the provision of services that are both more appropriate and more cost-efficient;

(IV) Current federal medicaid regulations contain inherent barriers to providing appropriate palliative and end-of-life care to pediatric patients. These barriers include requirements that preclude the pursuit of curative treatments, mandate a do-not-resuscitate order, and require physician certification that death is expected within six months.

(b) The general assembly declares that it is in the best interest of the state to investigate and implement hospice guidelines that provide appropriate, compassionate care to dying children and their families while proving to be cost-neutral or cost-saving to the state and federal medicaid programs.

(c) The general assembly further finds and declares that, while this direction immediately concerns federal approval for hospice care that recognizes the distinct circumstances of children facing life-threatening illnesses and their families, it is the intent of the general assembly that the information and data produced as a result of this act shall be used to improve the delivery of palliative and end-of-life services to persons of all ages when such improvements can be made in a manner that is cost-neutral or cost-saving to the state.

(2) **Definitions.** As used in this section, unless the context otherwise requires:

(a) "Eligible child" means a child who:

(I) Is less than nineteen years of age; and

(II) Is eligible for the state's medicaid program pursuant to section ~~26-4-201~~, ~~26-4-301~~, or ~~26-4-303~~ 25.5-5-101, 25.5-5-201, OR 25.5-5-203.

(b) "Pediatric hospice care" means hospice care for eligible children as authorized in this section.

(3) **Pediatric hospice care.** (a) (I) The state department shall seek the appropriate federal authorization, conditioned on the receipt of gifts, grants, or donations sufficient to provide for the state's administrative costs of preparing and submitting the request, for pediatric hospice care that shall include but may not be limited to:

(A) Respite care;

(B) Expressive therapies, as defined in rule by the state board;

(C) Palliative care from the time of diagnosis of a potentially life-threatening illness; and

(D) A continuum of care through the coordination of services, which may include skilled, intermittent, and around-the-clock nursing care.

(II) The state department is authorized to seek federal approval for modifications to the provision of hospice care for adults who are eligible for the state's medicaid program.

(b) For the provision of pediatric hospice care, the state department shall seek an exemption from the following federal medicaid requirements for the eligibility of and election for hospice care:

(I) The mandatory do-not-resuscitate order;

(II) A physician's certification that a patient is expected to live less than six months; and

(III) The non-allowance of curative care therapies concurrent with palliative and hospice care.

(c) In any application for federal authorization pursuant to this section, the state department shall retain bereavement services to the extent available under federal law.

(d) Pediatric hospice care, as authorized pursuant to this section, shall meet aggregate federal waiver budget neutrality requirements.

(e) The state department shall implement the provision of pediatric hospice care to the extent authorized by the federal government.

(4) **Review.** The state department shall notify the joint budget committee of the general assembly of the extent to which the state department received federal authorization for pediatric hospice care services pursuant to this section in order for the joint budget committee to review the approved budget neutrality analysis for such services prior to the state department's implementation.

(5) **Rules.** The state department shall develop the service provisions for pediatric hospice care in consultation with medical professionals who have expertise in providing end-of-life and palliative care to pediatric patients and family members who have experienced the death of a child. The state board shall adopt rules necessary to implement and administer the provisions of this section.

(6) **Fund.** ~~(a)~~ The state department is authorized to seek and accept gifts, grants, or donations from private or public sources for the purpose of providing for the administrative costs of preparing and submitting the request for federal approval for the provision of pediatric hospice care. All private and public funds received through gifts, grants, or donations shall be transmitted to the state treasurer, who shall credit the same to the pediatric hospice care cash fund, which fund is hereby created and referred to in this section as the "fund". The moneys in the fund shall be subject to annual appropriation by the general assembly for preparing and submitting the request for federal approval pursuant to this section. Any moneys in the fund not expended for the purpose of this section may be invested by the state treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund. Any unexpended and unencumbered moneys remaining in the fund at the end of a fiscal year shall

remain in the fund and shall not be credited or transferred or revert to the general fund or another fund.

~~(b) If sufficient moneys have not been credited to the fund for the purpose of preparing the request for federal authorization required under this section prior to January 1, 2005, the state treasurer shall immediately provide notification of such fact to the state department and to the revisor of statutes.~~

~~(c) This section is repealed upon receipt by the revisor of statutes of the notification described in paragraph (b) of this subsection (6).~~

25.5-5-306. [Formerly 26-4-527] Residential child health care - waiver - program. (1) The STATE department, ~~of health care policy and financing~~ in cooperation with the department of human services, shall implement a program concerning residential child health care under this article AND ARTICLES 4 AND 6 OF THIS TITLE to provide services pursuant to article 10.3 of title 27, C.R.S., to medicaid-eligible children residing in residential child care facilities, as that term is defined in section 26-6-102 (8), C.R.S., and children placed through county departments of social services in licensed or certified out-of-home placement facilities. Children with developmental disabilities, as defined in section 27-10.5-102 (11), C.R.S., who are placed in such facilities shall meet the out-of-home placement criteria described in section 19-1-107, C.R.S., and shall be neglected or dependent as described in section 19-3-102, C.R.S. The ~~medical services~~ STATE board shall establish the type of rehabilitative or medical assistance services to be provided under the program as described in subsection (3) of this section, to the extent such services are cost-efficient, and the recipient eligibility criteria that may include, but are not limited to, a medical necessity determination and a financial eligibility determination.

(2) The STATE department, ~~of health care policy and financing~~ in cooperation with the department of human services, may limit the number of recipients or providers participating in the program in accordance with any federal waiver obtained by the state department to implement this section.

(3) The ~~department of health care policy and financing~~, STATE BOARD, in cooperation with the department of human services, shall promulgate rules as necessary for the implementation of the program, including, but not limited to, rules regarding program services that may include rehabilitative services as appropriate to residential child health care when referred by a physician licensed pursuant to article 36 of title 12, C.R.S., a psychologist licensed pursuant to part 3 of article 43 of title 12, C.R.S., a registered professional nurse as defined in section 12-38-103 (11), C.R.S., who, by reason of postgraduate education and additional nursing preparation, has gained knowledge, judgment, and skill in psychiatric or mental health nursing, a clinical social worker licensed pursuant to part 4 of article 43 of title 12, C.R.S., a marriage and family therapist licensed pursuant to part 5 of article 43 of title 12, C.R.S., or a professional counselor licensed pursuant to part 6 of article 43 of title 12, C.R.S.; the number of recipients participating; eligibility criteria including financial eligibility criteria; reimbursement of providers; and such other rules as are necessary for the implementation and administration of the program. The twenty percent county contribution established in section 26-1-122, C.R.S., for residential child care facilities may be used by the state to obtain federal

financial participation under Title XIX of the social security act for any residential child health care program established pursuant to this section. The twenty percent contribution shall not be increased due to any federal financial participation received as a result of any programs established pursuant to this section. Nothing in this section shall be construed to prohibit an adjustment in the county contribution due to caseload or service cost increases. Nothing in this section shall be construed to create a county obligation to directly participate in the financing of any program established pursuant to the "Colorado Medical Assistance Act" as set forth in this article AND ARTICLES 4 AND 6 OF THIS TITLE.

~~(4) and (5) (Deleted by amendment, L. 95, p. 914, § 11, effective May 25, 1995.)~~

25.5-5-307. [Formerly 26-4-509.5] Child mental health treatment and family support program. (1) The general assembly finds that many parents in Colorado who have experienced challenging circumstances because their children have significant mental health needs and who have attempted to care for their children or seek services on their behalf often are burdened with the excessive financial and personal costs of providing such care. Private insurance companies may not cover mental health services and rarely cover residential mental health treatment services; those that do seldom cover a sufficient percentage of the expense to make such mental health treatment a viable option for many families in need. The result is that many families do not have the ability to obtain the mental health services that they feel their children desperately need. The general assembly finds that it is in the best interests of these families and the citizens of the state to encourage the preservation of family units by making mental health treatment available to these children pursuant to article 10.3 of title 27, C.R.S.

(2) In order to make mental health treatment available, it is the intent of the general assembly that each medicaid-eligible child who is diagnosed as a mentally ill person, as that term is defined in section 27-10-102 (7), C.R.S., shall receive mental health treatment, which may include in-home family mental health treatment, other family preservation services, residential treatment, or any post-residential follow-up services, that shall be paid for through federal medicaid funding.

25.5-5-308. [Formerly 26-4-532] Breast and cervical cancer prevention and treatment program - creation - legislative declaration - definitions - funds - repeal. (1) The general assembly hereby finds and declares that breast and cervical cancer are significant health problems for women in this state. The general assembly further finds and declares that these cancers can and should be prevented and treated whenever possible. It is therefore the intent of the general assembly to enact this section to provide for the prevention and treatment of breast and cervical cancer to women where it is not otherwise available for reasons of cost.

(2) As used in this section, unless the context otherwise requires:

(a) "Eligible person" means a person who:

(I) Has been screened for breast or cervical cancer under the centers for disease control and prevention's national breast and cervical cancer early detection program established under Title XV of the federal "Public Health Service Act", 42 U.S.C. sec. 300k et seq., in accordance with the requirements of section 1504 of such act,

42 U.S.C. sec. 300n, on or after July 1, 2002, unless the centers for medicare and medicaid services approves the state department's amendment to the medical assistance plan and the state department is able to implement the breast and cervical cancer prevention and treatment program before such date, then the person must be screened on or after the implementation date of such program;

(II) Has been diagnosed with breast or cervical cancer and is in need of breast or cervical cancer treatment;

(III) Has not yet attained sixty-five years of age; and

(IV) Does not have any creditable coverage as defined under federal law pursuant to 42 U.S.C. sec. 300gg (c).

(b) "Qualified entity" shall be defined pursuant to 42 U.S.C. sec. 1396r-1b(b)(2).

~~(c) "State board" means the medical services board created in section 25.5-1-301, C.R.S.~~

(3) There is hereby created a breast and cervical cancer prevention and treatment program to provide medical benefits to eligible persons under this section.

(4) (a) Benefits for medical assistance to an eligible person shall be made available beginning on the day on which a determination is made that the person is eligible for medical assistance and throughout the period in which such person meets the definition of an eligible person.

(b) Benefits for medical assistance to an eligible person shall also be available for the following period of presumptive eligibility:

(I) Such period of presumptive eligibility shall begin when a qualified entity determines that the eligible person is in need of treatment for breast or cervical cancer.

(II) Such period of presumptive eligibility shall end with the earlier of:

(A) The day on which a determination is made that the person is eligible or not eligible for medical assistance; or

(B) If the eligible person does not file a simplified application for medical assistance developed by the state department and approved by the centers for medicare and medicaid services on or before the last day of the month following the month during which the eligible person was found to be qualified for services under this section, then benefits shall end on such last day.

(5) The state department shall have the following powers and duties:

(a) To establish, operate, and monitor the breast and cervical cancer prevention and treatment program to provide medical assistance to eligible persons in accordance with the provisions of the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000", enacted October 24, 2000, P.L. 106-354,

as amended;

(b) To amend the state's medical assistance plan to incorporate the breast and cervical cancer prevention and treatment program. The state department shall submit such proposed amendment to the centers for medicare and medicaid services regional office for approval.

(c) To accept and expend any grant or award of moneys from the federal government, any moneys appropriated by the general assembly, any moneys received through gifts, grants, or donations from nonprofit or for-profit entities, and any interest and income earned on such moneys for the purposes set forth in this section;

(d) To inform the joint budget committee of the general assembly in writing as soon as practicable about any change in the rate of federal financial participation in the program.

(6) The state board shall adopt such rules as are necessary to carry out the provisions of this section.

~~(6.5)~~ (7) The breast and cervical cancer prevention and treatment program shall be subject to the annual financial and compliance audit of the "Colorado Medical Assistance Act" performed by the state auditor's office and shall not be considered a tobacco settlement program for purposes of section 2-3-113, C.R.S., or section 25-1-108.5, C.R.S.

~~(7)~~ (8) There is hereby created in the state treasury the breast and cervical cancer prevention and treatment fund, referred to in this subsection ~~(7)~~ (8) as the "fund". The fund shall consist of any moneys credited thereto pursuant to section 24-22-115 (1), C.R.S., any gifts, grants, and donations, and any moneys appropriated thereto by the general assembly. All moneys credited to the fund and all interest and income earned on the moneys in the fund shall remain in the fund for the purposes set forth in this section. No moneys credited to the fund shall be transferred to or revert to the general fund of the state at the end of any fiscal year. The state department is encouraged to secure private gifts, grants, and donations to fund the state costs of the breast and cervical cancer prevention and treatment program.

~~(7.5)~~ (9) (a) For the fiscal year 2005-06, the general assembly shall appropriate fifty percent of the state costs of the breast and cervical cancer prevention and treatment program from the general fund and fifty percent from the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.

(b) For the fiscal years 2006-07 and 2007-08, the general assembly shall appropriate seventy-five percent of the state costs of the breast and cervical cancer prevention and treatment program from the general fund and twenty-five percent from the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.

(c) For the fiscal year 2008-09 the general assembly shall appropriate one hundred percent of the state costs of the breast and cervical cancer prevention and

treatment program to such program.

(8) (10) This section is repealed, effective July 1, 2009, unless, in any fiscal year before such date, moneys received as federal financial participation provided pursuant to the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000", enacted October 24, 2000, P.L. 106-354, as amended, are no longer available to the fund or the rate of federal financial participation has been decreased, in which case the general assembly may repeal this section at the regular session of the general assembly immediately following such decrease or discontinuation of federal moneys.

25.5-5-309. [Formerly 26-4-508.2] Pregnant women - needs assessment - referral to treatment program. (1) The health care practitioner for each pregnant woman who is enrolled for services pursuant to section ~~26-4-508~~ 25.5-5-205 or who would be eligible for aid to families with dependent children pursuant to rules in effect on July 16, 1996, shall be encouraged to identify as soon as possible after such woman is determined to be pregnant whether such woman is at risk of a poor birth outcome due to substance abuse during the prenatal period and in need of special assistance in order to reduce such risk. If the health care practitioner makes such a determination regarding any pregnant woman, the health care practitioner shall be encouraged to refer such woman to any entity approved and ~~certified~~ LICENSED by the department of ~~health~~ HUMAN SERVICES for the performance of a needs assessment. Any pregnant woman who is eligible for services pursuant to section ~~26-4-508~~ 25.5-5-205 or who would be eligible for aid to families with dependent children pursuant to rules in effect on July 16, 1996, may refer herself for such needs assessment.

(2) For the purposes of this section, unless the context otherwise requires, a "needs assessment" means an assessment ~~which~~ THAT is designed to make a determination of what services are needed by a pregnant woman to minimize the occurrence of a poor birth outcome due to substance abuse by such pregnant woman.

25.5-5-310. [Formerly 26-4-508.4] Treatment program for high-risk pregnant women - cooperation with private entities. The STATE department ~~of health care policy and financing~~ and the departments of human services and public health and environment shall cooperate with any private entities ~~which~~ THAT desire to assist such departments in the provision of services connected with the treatment program for high-risk pregnant women. Private entities may provide services ~~which~~ THAT are not provided to persons pursuant to this article OR ARTICLE 4 OR 6 OF THIS TITLE or article 2 of this title 26, C.R.S., which may include, but shall not be limited to, needs assessment services, preventive services, rehabilitative services, care coordination, nutrition assessment, psychosocial counseling, intensive health education, home visits, transportation, development of provider training, child care, and other necessary components of residential or outpatient treatment or care.

25.5-5-311. [Formerly 26-4-508.5] Treatment program for high-risk pregnant women - data collection. The STATE department, ~~of health care policy and financing~~ in cooperation with the department of human services, shall create a data collection mechanism regarding persons receiving services pursuant to the treatment program for high-risk pregnant women which shall include the collection

of such data as such departments deem appropriate.

25.5-5-312. [Formerly 26-4-508.6] Treatment program for high-risk pregnant women - extended coverage - federal approval. The state department shall seek federal approval to continue providing substance abuse treatment services for twelve months following a pregnancy to women who are eligible to receive services under the medical assistance program, who are receiving services pursuant to the treatment program for high-risk pregnant women, and who continue to participate in the treatment program. The state department shall implement the continued services to the extent allowed by the federal government.

25.5-5-313. [Formerly 26-4-536] Outpatient substance abuse treatment - report of state auditor - amendment to state plan - repeal. (1) (a) On or before January 1, 2006, the state department shall amend the state plan of medical assistance to reflect the addition of this section and section ~~26-4-302 (1) (u)~~ 25.5-5-202 (1) (s).

(b) This subsection (1) is repealed, effective July 1, 2006.

(2) (a) On or before January 1, 2011, the state auditor shall submit a report to the legislative audit committee analyzing the costs and savings to the medical assistance program of providing outpatient substance abuse treatment.

(b) On or before March 31, 2011, based upon the report required by paragraph (a) of this subsection (2), if the legislative audit committee adopts a resolution finding that providing outpatient substance abuse treatment has resulted in an overall increase in costs to the medical assistance program, section ~~26-4-302 (1) (u)~~ 25.5-5-202 (1) (s) is repealed, effective July 1, 2011.

(3) This section is repealed, effective July 1, 2011.

25.5-5-314. [Formerly 26-4-422] Substance abuse treatment for native Americans - federal approval - repeal. (1) The state department shall request federal approval, conditioned on the receipt of gifts, grants, or donations sufficient to provide for the state's administrative costs of preparing and submitting the request, to include any substance abuse treatment benefits available to native Americans in which there is one hundred percent federal financial participation.

(2) (a) If sufficient moneys to support the cost of preparing a request for federal approval have not been credited to the native American substance abuse treatment cash fund established in section ~~26-4-423~~ 25.5-5-315 prior to December 31, 2004, the state treasurer shall immediately provide notification of such fact to the state department and to the revisor of statutes.

(b) This section is repealed upon receipt by the revisor of statutes of the notification described in paragraph (a) of this subsection (2).

25.5-5-315. [Formerly 26-4-423] Acceptance of gifts, grants, and donations - native American substance abuse treatment cash fund - repeal. (1) The executive director may accept and expend moneys from gifts, grants, and donations for purposes of providing for the administrative costs of preparing and submitting

the request for federal approval to provide substance abuse treatment services to native Americans as provided for in section ~~26-4-422~~ 25.5-5-314. All such gifts, grants, and donations shall be transmitted to the state treasurer who shall credit the same to the native American substance abuse treatment cash fund, which fund is hereby created. The moneys in the native American substance abuse treatment cash fund shall be subject to annual appropriation by the general assembly. All investment earnings derived from the deposit and investment of moneys in the native American substance abuse treatment cash fund shall remain in the fund and shall not be transferred or revert to the general fund of the state at the end of any fiscal year.

(2) (a) If sufficient moneys have not been credited to the native American substance abuse treatment cash fund for the purpose of preparing the request for federal approval required under section ~~26-4-422~~ 25.5-5-314 prior to December 31, 2004, the state treasurer shall immediately provide notification of such fact to the state department and to the revisor of statutes.

(b) This section is repealed upon receipt by the revisor of statutes of the notification described in paragraph (a) of this subsection (2).

25.5-5-316. [Formerly 26-4-408.5] Legislative declaration - state department - disease management programs authorization - report. (1) The general assembly finds that, because Colorado is faced with rising health care costs and limited resources, it is necessary to seek new ways to ensure the availability of high-quality, cost-efficient care for medicaid recipients. The general assembly further finds that disease management is a patient-focused, integrated approach to providing all components of care with attention to both quality of care and total cost. In addition, the general assembly finds that this approach may include coordination of physician care with pharmaceutical and institutional care. The general assembly further finds that disease management also addresses the various aspects of a disease state, including meeting the needs of persons who have multiple chronic illnesses. The general assembly declares that the improved coordination in disease management helps to provide chronically ill patients with access to the latest advances in treatment and teaches them how to be active participants in their health care through health education, thus reducing total health care costs.

(2) The state department is authorized to develop and implement disease management programs, for fee-for-service and primary care physician program recipients, that are designed to address over- or under-utilization or the inappropriate use of services or prescription drugs and that may affect the total cost of health care utilization by a particular medicaid recipient with a particular disease or combination of diseases. The disease management programs shall target medicaid recipients who are receiving prescription drugs or services in an amount that exceeds guidelines outlined by the state department. The state department shall not restrict a medicaid recipient's access to the most cost-effective and medically appropriate prescription drugs or services. The state department may contract on a contingency basis for the development or implementation of the disease management programs authorized in this subsection (2).

(3) If the state department implements any disease management programs authorized in subsection (2) of this section, the state department shall report to the

joint budget committee of the general assembly an estimate of the fiscal implications generated by the implementation of the disease management programs. Such report shall be made on or before February 1 of the year following the implementation of a disease management program and on or before each February 1 thereafter in which such program is in place.

25.5-5-317. [Formerly 26-4-534] Obesity treatment pilot program - development and implementation - report - repeal. (1) (a) Contingent on the conditions specified in subsection (3) of this section, the state department shall develop and implement an obesity treatment pilot program for the purpose of treating a medicaid recipient who has a body mass index that is equal to or greater than thirty and who has a comorbidity related to the recipient's obesity including but not limited to diabetes, hypertension, and coronary heart disease. The pilot program shall be designed to treat a recipient through the use of behavioral modification, self-management training, and medication when medication is medically necessary. The state department shall not restrict a recipient's access to medically appropriate services under this pilot program.

(b) It is the general assembly's intent that the implementation of the obesity treatment pilot program authorized in this section shall be cost effective for the state's medical assistance program. General fund moneys shall not be appropriated to fund the obesity treatment pilot program for either fiscal year 2005-06 or fiscal year 2006-07. If an independent study demonstrates that the obesity treatment pilot program reduces state expenditures for medical services premiums, then the general assembly may appropriate general fund moneys that would otherwise be appropriated for medical services premiums to fund a continuation of the pilot program after June 30, 2007.

(2) The state department shall report to the joint budget committee of the general assembly on the effectiveness of the obesity treatment pilot program and shall provide an estimate of the fiscal implications generated by the implementation of the pilot program. The state department shall report on or before February 1, 2007, and on or before each February 1 thereafter in which the obesity treatment pilot program is in place.

(3) (a) The state department may contract on a contingency basis and may accept gifts, grants, and donations for the development and implementation of the obesity treatment pilot program authorized in subsection (1) of this section.

(b) The state department shall develop and implement the obesity treatment pilot program authorized in subsection (1) of this section only if the state department receives sufficient gifts, grants, or donations for the development and implementation of the obesity treatment pilot program.

(4) This section is repealed, effective July 1, 2010. Prior to such repeal, the obesity treatment pilot program implemented by the state department pursuant to this section shall be reviewed as provided for in section 24-34-104, C.R.S.

25.5-5-318. [Formerly 26-4-531] Health services - provision by school districts. (1) As used in this section:

~~(a) "Executive director" means the executive director of the department of health care policy and financing.~~

~~(b)~~ (a) "School district" means any board of cooperative services established pursuant to article 5 of title 22, C.R.S., any state educational institution that serves students in kindergarten through twelfth grade including, but not limited to, the Colorado school for the deaf and the blind, created in article 80 of title 22, C.R.S., and any public school district organized under the laws of Colorado, except a junior college district.

~~(c) "State department" means the department of health care policy and financing.~~

~~(d)~~ (b) "Underinsured" means a person who has some health insurance, but whose insurance does not adequately cover the types of health services for which a school district may receive federal matching funds under this section.

(2) (a) Any school district may contract with the state department under this section to receive federal matching funds for amounts spent in providing health services through the public schools to students who are receiving medicaid benefits pursuant to this article AND ARTICLES 4 AND 6 OF THIS TITLE.

(b) Approval of contracts under this section does not constitute a commitment by the general assembly to continue providing health services to students through the public schools using state general funds if federal matching funds are not available in the future. Any moneys provided to a school district pursuant to a contract entered into under this section shall not supplant state or local moneys provided to school districts pursuant to the provisions of articles 20 to 28 or article 54 of title 22, C.R.S.

(c) Nothing in this section shall be construed as requiring any school district to enter into a contract as provided in this section. Participation in a contract by a school district is voluntary.

(d) The state department may make contracting and reimbursement of moneys under this section contingent upon either:

(I) The contracting school district certifying to the state department, through the department of education, that it has expended local and state moneys in an amount sufficient to meet the nonfederal share of expenditures being claimed for federal financial participation; or

(II) The contracting school district meeting the requirements of the intergovernmental transfer provisions of the federal medicaid law, 42 U.S.C. sec. 1396, et seq.

(3) Each year, by a date established by rule of the ~~medical services~~ STATE board, the department of education shall notify the state department concerning any school district that chooses to enter into a contract as provided in this section and the anticipated level of funding for the school district. Nothing in this section shall be construed to require a school district to maintain the same level of funding or services from year to year.

(4) (a) (I) Each school district that chooses to enter into a contract as provided in this section shall develop a services plan with input from the local community that identifies the types of health services needed by students within the school district and the services it anticipates providing. Except for medical emergencies and services related to allegations of child abuse, a student's participation in any psychological, behavioral, social, or emotional services, including counseling or referrals, shall be optional and shall require the prior written and informed consent of a parent or legal guardian of the student.

(II) (A) Any health questionnaire or form related to services funded in part through this section shall only relate to the student's personal health, habits, or conduct and shall not include questions concerning the habits or conduct of any other member of the student's family.

(B) No medical or health data or information identifying the student or the student's family shall be disclosed to any person other than a person specifically authorized to receive the information or data without the prior written and informed consent of a parent or legal guardian of the student.

(b) Each school district that chooses to enter into a contract as provided in this section shall perform an assessment of the health care needs of its uninsured and underinsured students and may spend an appropriate portion, not to exceed thirty percent, of the federal moneys received on health care for low-income students. For purposes of this paragraph (b), low-income students means students whose families are below one hundred eighty-five percent of the federal poverty level.

(c) The school district shall submit the services plan to the department of education with a notice of participation for purposes of technical assistance evaluation and to the executive director for approval.

(5) Each year not less than ninety days prior to the notification date established pursuant to subsection (3) of this section, the state department shall provide information through the department of education to school districts regarding the amount of available moneys and the administrative activities required to enter into a contract for federal matching funds for that year. To the extent allowed by existing resources, the department of education shall provide technical assistance to school districts in determining levels of funding, meeting administrative requirements, and developing services plans.

(6) Following the notification date established pursuant to subsection (3) of this section, each contracting school district, through the department of education, shall enter into a contract with the state department specifying the health services to be provided by the school district, the amount to be expended in providing the services, and the amount of federal matching funds for which the school district is eligible under the contract.

(7) The state department is authorized to accept and expend donations, contributions, grants, including federal matching funds, and other moneys that it may receive to finance the costs associated with implementing this section.

(8) (a) Under the contract entered into pursuant to this section, a contracting

school district shall receive from the state department all of the federal matching funds for which it is eligible under the contract, less the amount of state administrative costs allowed under paragraph (b) of this subsection (8). All moneys received by a school district pursuant to this section shall be used only to offset costs incurred for provision of student health services by the school district or to cash fund student health services in the school district.

(b) Total allowable state administrative costs for contracts entered into under this section for both the state department and the department of education shall not exceed ten percent of the total annual amount of federal funds reflected by the general assembly for such contracts in the annual general appropriations bill. State administrative costs include costs incurred in evaluating the implementation of this section.

(9) The STATE board of medical services shall specify by rule the types of health services for which a school district may receive federal matching funds under a contract created under this section, including but not limited to:

- (a) Basic primary, physical, dental, and mental health services;
- (b) Rehabilitation services;
- (c) Early and periodic screening, diagnosis, and treatment services; and
- (d) Service coordination, outreach, enrollment, and administrative support.

(10) (a) A school district that provides health services under contract pursuant to this section may provide the health services directly or through contractual relationships or agreements with public or private entities, as allowed by applicable federal regulations. However, no moneys shall be expended in any form for abortions, except as provided in section ~~26-4-512~~ 25.5-4-415 or as required by federal law.

(b) Where possible, the school district shall coordinate the provision of health services to a student with the student's primary health care provider. Except for those services that are required by an individual educational program developed pursuant to section 22-20-108 (4), C.R.S., or by a section 504 plan developed pursuant to the federal "Rehabilitation Act of 1973", 29 U.S.C. sec. 701, et seq., school districts shall not claim reimbursement under this section for direct services to students enrolled in health maintenance organizations that would normally be provided to students by their health maintenance organization.

(11) (a) The executive director shall apply for and secure any federal waivers and state plan amendments required to implement this section.

(b) This section shall remain in effect only for so long as federal financial participation is available for reimbursements to school districts. In the event, as specified in writing by the attorney general to the governor that federal law does not allow or is amended to disallow reimbursements to school districts or otherwise prevent the implementation of this section, this section is repealed, effective on the date of the attorney general's opinion.

(12) The state department and the department of education shall work with the office of state planning and budgeting and the joint budget committee in implementing this section.

(13) The state department and the department of education shall enter into an interagency agreement to provide for the implementation of this section. The ~~medical services~~ STATE board and the state board of education are authorized to promulgate rules as may be necessary in accordance with the agreement.

(14) The state department shall annually, or more often as necessary, hold a public hearing to receive comments from school districts, state agencies, and interested persons regarding implementation of this section.

(15) On or before December 15, 2002, the state department shall submit a formal evaluation of the implementation of this section to the committees on education and the committees on ~~health, environment, welfare, and institutions~~ HEALTH AND HUMAN SERVICES of the house of representatives and the senate, OR ANY SUCCESSOR COMMITTEES.

25.5-5-319. [Formerly 26-4-414.7] Family planning pilot program - rules - federal waiver - repeal. (1) There is hereby established a family planning pilot program for the provision of family planning services to categorically eligible individuals who are at or below one hundred fifty percent of the federal poverty level. The ~~medical services~~ STATE board shall promulgate rules setting forth the family planning services to be provided under the family planning pilot program.

(2) The executive director of the state department, in consultation with the department of public health and environment, shall seek a federal waiver that is cost-neutral to the state general fund for the implementation of the family planning pilot program established pursuant to this section such that ten percent of the family planning services provided to low-income families pursuant to the program as described in subsection (1) of this section would be funded with state general fund moneys and ninety percent would be funded with federal matching funds.

(3) (a) Upon issuance of the federal waiver sought pursuant to subsection (2) of this section, the departments of health care policy and financing and public health and environment shall seek the necessary appropriation of general funds through the normal budgetary process for the implementation of this act.

(b) The executive director of the state department is authorized to accept and expend on behalf of the state any funds, grants, gifts, and donations from any private or public source for the purpose of implementing the family planning pilot program established in this section; except that no gift, grant, donation, or funds shall be accepted if the conditions attached thereto require the expenditure thereof in a manner contrary to law.

(4) The executive director of the state department, or such executive director's designee, shall prepare a written report for the members of the general assembly concerning the findings of the department based upon the family planning pilot program. Such report shall be provided to the members of the general assembly not more than three years after commencement of the program. The report shall address

the number of individuals served, the type of services provided, the cost of the program, and such other information as the executive director deems appropriate.

(5) The implementation of this section is conditioned upon the issuance of any necessary waiver by the federal government and available appropriations pursuant to paragraph (a) of subsection (3) of this section. The provisions of this section shall be implemented to the extent authorized by federal waiver. The pilot program established by this section shall continue for five years from the receipt of the federal waiver or for so long as specified in the federal waiver. The executive director of the state department shall provide written notice to the revisor of statutes of the final termination date of the waiver, and this section shall be repealed, effective July 1 five years after the issuance of the federal waiver or July 1 in the year in which the waiver is terminated, whichever occurs first.

PART 4 STATEWIDE MANAGED CARE SYSTEM

25.5-5-401. [Formerly 26-4-111] Short title. ~~This subpart 2 consists of sections 26-4-111 to 26-4-130 and may be cited as subpart 2. The title of this subpart 2~~ THIS PART 4 shall be known and may be cited as the "Statewide Managed Care System".

25.5-5-402. [Formerly 26-4-113] Statewide managed care system. (1) The state ~~department~~ BOARD shall adopt rules to implement a managed care system for Colorado medical assistance clients pursuant to the provisions of this article AND ARTICLES 4 AND 6 OF THIS TITLE. The statewide managed care system shall be implemented to the extent possible.

~~(1.5)~~ (2) The managed care system implemented pursuant to this article shall not include:

(a) The services delivered under the residential child health care program described in section ~~26-4-527~~ 25.5-5-306, except in those counties in which there is a written agreement between the county department of social services, the designated and contracted ~~mental health assessment and services agency~~ BEHAVIORAL HEALTH ORGANIZATION selected pursuant to section ~~26-4-123~~ 25.5-5-411, and the state department;

(b) Long-term care services ~~except for the integrated care and financing project, as described in section 26-4-122~~; and the program of all-inclusive care for the elderly, as described in section ~~26-4-124~~ 25.5-5-412. For purposes of this subsection ~~(1.5)~~ (2), "long-term care services" means nursing facilities and home- and community-based services provided to eligible clients who have been determined to be in need of such services pursuant to the "Colorado Medical Assistance Act" and the state ~~department's~~ BOARD'S rules.

~~(2) (Deleted by amendment, L. 2002, p. 822, § 2, effective July 1, 2002.)~~

(3) **Bidding.** The state department is authorized to institute a program for competitive bidding pursuant to section 24-103-202 or 24-103-203, C.R.S., for

managed care organizations seeking to provide medical services for medicaid clients eligible to be enrolled in managed care. The state department is authorized to award contracts to more than one offeror. The state department procedures shall seek to use competitive bidding procedures to maximize the number of managed care choices available to medicaid clients over the long term that meet the requirements of sections ~~26-4-115 and 26-4-117~~ 25.5-5-404 AND 25.5-5-406.

(4) **Waivers.** The implementation of this ~~subpart 2~~ PART 4 is conditioned, to the extent applicable, on the issuance of necessary waivers by the federal government. The provisions of this ~~subpart 2~~ PART 4 shall be implemented to the extent authorized by federal waiver, if so required by federal law.

~~(5) (Deleted by amendment, L. 2002, p. 822, § 2, effective July 1, 2002.)~~

~~(6)~~ (5) **Graduate medical education.** The state department shall continue the graduate medical education, referred to in this subsection ~~(6)~~ (5) as "GME", funding to teaching hospitals that have graduate medical education expenses in their medicare cost report and are participating as providers under one or more MCO with a contract with the state department under this ~~subpart 2~~ PART 4. GME funding for recipients enrolled in an MCO shall be excluded from the premiums paid to the MCO and shall be paid directly to the teaching hospital. The ~~medical services~~ STATE board shall adopt rules to implement this subsection ~~(6)~~ (5) and establish the rate and method of reimbursement.

~~(7) (a) to (c) (Deleted by amendment, L. 2002, p. 822, § 2, effective July 1, 2002.)~~

~~(f) (Deleted by amendment, L. 2000, p. 2011, § 14, effective June 3, 2000.)~~

~~(8) (Deleted by amendment, L. 2000, p. 2011, § 14, effective June 3, 2000.)~~

~~(9) (Deleted by amendment, L. 2002, p. 822, § 2, effective July 1, 2002.)~~

~~(10) Repealed.~~

25.5-5-403. [Formerly 26-4-114] Managed care organizations - definitions.

(1) (a) **Managed care.** As used in this ~~subpart 2~~ PART 4, "managed care" means:

(I) The delivery by a managed care organization, as defined in subsection (2) of this section, of a predefined set of services to recipients; or

(II) The delivery of services provided by the primary care physician program established in section ~~26-4-118~~ 25.5-5-407.

(b) Nothing in this section shall be deemed to affect the benefits authorized for recipients of the state medical assistance program.

(2) **Managed care organization.** As used in this ~~subpart 2~~ PART 4, "managed care organization", referred to in this ~~subpart 2~~ PART 4 as an "MCO", means an entity contracting with the state department that provides, delivers, arranges for, pays for, or reimburses any of the costs of health care services through the

recipient's use of health care providers managed by, owned by, under contract with, or employed by the entity because the entity or the state department either requires the recipient's use of those providers or creates incentives, including financial incentives, for the recipient's use of those providers.

(3) **Essential community provider.** "Essential community provider" or "ECP" means a health care provider that:

(a) Has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low-income and medically indigent populations who make up a significant portion of its patient population or, in the case of a sole community provider, serves the medically indigent patients within its medical capability; and

(b) Waives charges or charges for services on a sliding scale based on income and does not restrict access or services because of a client's financial limitations.

25.5-5-404. [Formerly 26-4-115] Selection of managed care organizations.

~~(1) (Deleted by amendment, L. 2002, p. 826, § 4, effective July 1, 2002.)~~

~~(2)~~ (1) In addition to any other criteria specified in rule by the ~~medical services~~ STATE board, in order to participate in the managed care system, the MCO shall comply with specific criteria that include, but are not limited to, the following:

(a) The MCO shall not interfere with appropriate medical care decisions rendered by the provider nor penalize the provider for requesting medical services outside the standard treatment protocols developed by the MCO or its contractors;

(b) The MCO shall make or assure payments to providers within the time allowed for the state to make payments on state liabilities under the rules adopted by the department of personnel pursuant to section 24-30-202 (13), C.R.S.;

(c) The MCO shall have an educational component in its plan that takes into consideration recipient input and that informs recipients as to availability and use of the medical services system, appropriate preventive health care procedures, self-care, and appropriate health care utilization;

(d) The MCO shall provide the minimum benefit requirements as established by the ~~medical services~~ STATE board;

(e) The MCO shall provide necessary and appropriate services to recipients that shall include but not be limited to the following:

(I) With respect to recipients who are unable to make decisions for themselves, the MCO and all relevant providers in the MCO's network serving the recipients shall collaborate with the designated advocate or family member in all decision-making including enrollment and disenrollment;

(II) The MCO shall deliver services that are covered benefits in a manner that accommodates or is compatible with the recipient's ability to fulfill duties and

responsibilities in work and community activities;

(f) The MCO shall provide appropriate use of ancillary health care providers by appropriate qualified health care professionals;

(g) The MCO shall comply with all data collection and reporting requirements established by the state department;

(h) The MCO shall, to the extent provided by law or waiver, provide recipient benefits that the ~~medical services~~ STATE board shall develop and the state department shall implement in partnership with local government and the private sector, including but not limited to:

(I) Recipient options to rent, purchase, or own durable medical equipment;

(II) Recognition for improved health status outcomes; or

(III) Receipt of medical disposable supplies without charge;

(i) The MCO shall comply with utilization requirements established by the state department;

(j) The MCO shall develop and utilize a form or process for measuring group and individual recipient health outcomes, including but not limited to the use of tools or methods that identify increased health status or maintenance of the individual's highest level of functioning, determine the degree of medical access, and reveal recipient satisfaction and habits. Such tools shall include the use of client surveys, anecdotal information, complaint and grievance data, and disenrollment information. The MCO shall annually submit a care management report to the state department that describes techniques used by the MCO to provide more efficient use of health care services, better health status for populations served, and better health outcomes for individuals.

(k) Except as provided for in paragraph ~~(k-2)~~ (m) of this subsection ~~(2)~~ (1), for capitation payments effective on and after July 1, 2003, the MCO shall certify the financial stability of the MCO pursuant to criteria established by the division of insurance and shall certify, as a condition of entering into a contract with the state department, that the capitation payments set forth in the contract between the MCO and the state department are sufficient to assure the financial stability of the MCO with respect to delivery of services to the medicaid recipients covered in the contract;

~~(k-1)~~ (l) Except as provided for in paragraph ~~(k-2)~~ (m) of this subsection ~~(2)~~ (1), for capitation payments effective on and after July 1, 2003, the MCO shall certify, through a qualified actuary retained by the MCO, that the capitation payments set forth in the contract between the MCO and the state department comply with all applicable federal and state requirements that govern said capitation payments. For purposes of this paragraph ~~(k-1)~~ (l), a "qualified actuary" means a person deemed as such by rule promulgated by the commissioner of insurance.

~~(k-2)~~ (m) An MCO providing services under the PACE program as described in

section ~~26-4-124~~ 25.5-5-412 shall certify that the capitation payments are in compliance with applicable federal and state requirements that govern said capitation payments and that the capitation payments are sufficient to assure the financial viability of the MCO with respect to the delivery of services to the PACE program participants covered in the contract;

~~(n)~~ (n) The MCO shall provide assurance that the MCO has not provided to a recipient any premiums or other inducements in exchange for the recipient selecting the MCO for coverage;

~~(m)~~ (o) The MCO has established a grievance procedure pursuant to the provisions in section ~~26-4-117~~ 25.5-5-406 (1) (b) that allows for the timely resolution of disputes regarding the quality of care, services to be provided, and other issues raised by the recipient. Matters shall be resolved in a manner consistent with the medical needs of the individual recipient. The MCO shall notify all recipients involved in a dispute with the MCO of their right to seek an administrative review of an adverse decision made by the MCO pursuant to section 25.5-1-107. ~~E.R.S.~~

~~(m)~~ (p) With respect to pregnant women and infants, the MCO shall comply with the following:

(I) Enrollment of pregnant women without restrictions and including an assurance that the health care provider shall provide timely access to initiation of prenatal care in accordance with practice standards;

(II) Coverage without restrictions for newborns, including services such as, but not limited to, preventive care, screening, and well-baby examinations during the first month of life;

(III) The imposition of performance standards and the use of quality indicators with respect to perinatal, prenatal, and postpartum care for women and birthing and neonatal care for infants. The standards and indicators shall be based on nationally approved guidelines.

(IV) Follow-up basic health maintenance services for women and children, including immunizations and early periodic screening, diagnosis, and treatment services for children and appropriate preventive care services for women;

~~(o)~~ (q) The MCO shall accept all enrollees regardless of health status;

~~(p)~~ (r) The MCO shall comply with disclosure requirements as established by the state department and the ~~medical services~~ STATE board;

~~(q)~~ (s) The MCO shall provide a mechanism whereby a prescribing physician can request to override restrictions to obtain medically necessary off-formulary prescription drugs, supplies, equipment, or services for his or her patient;

~~(r)~~ (t) The MCO shall maintain a network of providers sufficient to assure that all services to recipients will be accessible without unreasonable delay. The state department shall develop explicit contract standards, in consultation with

stakeholders, to assess and monitor the MCO's criteria. Sufficiency shall be determined in accordance with the requirements of this paragraph ~~(r)~~ (t) and may be established by reference to any reasonable criteria used by the MCO including but not limited to the following:

(I) Geographic accessibility in regard to the special needs of recipients;

(II) Waiting times for appointments with participating providers;

(III) Hours of operation;

(IV) Volume of technological and specialty services available to serve the needs of recipients requiring technologically advanced or specialty care;

~~(s)~~ (u) (I) For the delivery of prescription drug benefits to recipients enrolled in an MCO who are residents of a nursing facility, MCOs shall use pharmacies with a demonstrated capability of providing prescription drugs in a manner consistent with the needs of clients in institutional settings such as nursing facilities. In cases where a nursing facility and a pharmacy have a contract for a single pharmacy delivery system for residents of the nursing facility:

(A) An MCO providing prescription drug benefits for residents of the nursing facility shall agree to contract with that pharmacy under reasonable contract terms; and

(B) The pharmacy shall agree to contract with each MCO that provides prescription drug benefits for residents of the nursing facility under reasonable contract terms.

(II) Any disputes concerning providing prescription drug benefits between nursing facilities, pharmacies, and MCOs that cannot be resolved through good faith negotiations may be resolved through a party requesting an informal review by the state department.

(III) ~~The medical services~~ STATE board shall adopt rules requiring MCOs to contract with qualified pharmacy providers in a manner permitting a nursing facility to continue to comply with federal medicaid requirements of participation for nursing facilities. Such rules shall define "qualified pharmacy providers" and shall be based upon consultations with nursing facilities, MCOs, pharmacies, and medicaid clients. The state department shall provide MCOs with a list of pharmacies that have a contract with nursing facilities serving recipients in nursing facilities in each county in which the MCO is contracting with the state department.

~~(3)~~ ~~(a)~~ (2) The MCO shall seek proposals from each ECP in a county in which the MCO is enrolling recipients for those services that the MCO provides or intends to provide and that an ECP provides or is capable of providing. To assist MCOs in seeking proposals, the state department shall provide MCOs with a list of ECPs in each county. The MCO shall consider such proposals in good faith and shall, when deemed reasonable by the MCO based on the needs of its enrollees, contract with ECPs. Each ECP shall be willing to negotiate on reasonably equitable terms with each MCO. ECPs making proposals under this subsection ~~(3)~~ (2) must be able to

meet the contractual requirements of the MCO. The requirements of this subsection ~~(3)~~ (2) shall not apply to an MCO in areas in which the MCO operates entirely as a group model health maintenance organization.

~~(b) (Deleted by amendment, L. 2002, p. 826, § 4, effective July 1, 2002.)~~

~~(4)~~ (3) In selecting MCOs, the state department shall not penalize an MCO for paying cost-based reimbursement to federally qualified health centers as defined in the "Social Security Act".

~~(5)~~ (4) (a) Notwithstanding any waivers authorized by the federal department of health and human services, OR ANY SUCCESSOR AGENCY, each contract between the state department and an MCO selected to participate in the statewide managed care system under this ~~subpart 2~~ PART 4 shall comply with the requirements of 42 U.S.C. sec. 1396a (a) (23) (B).

(b) Each MCO shall advise its enrollees of the services available pursuant to this subsection ~~(5)~~ (4).

~~(6)~~ (5) Nothing in this ~~subpart 2~~ PART 4 shall be construed to create an exemption from the applicable provisions of title 10, C.R.S.

~~(7)~~ (6) Nothing in this ~~subpart 2~~ PART 4 shall be construed to create an entitlement to an MCO to contract with the state department.

25.5-5-405. [Formerly 26-4-116] Quality measurements. (1) The state department shall measure quality pursuant to the following criteria:

(a) Quality shall be measured and considered based upon individuals and groups with the satisfaction of the service received analyzed and compared to nonrecipient populations for the same or similar services when available.

(b) Quality shall focus on health status or maintenance of the individual's highest level of functioning, without strict adherence to statistical norms.

(2) The state ~~department~~ BOARD shall promulgate rules ~~and regulations~~ to clarify and administer quality measurements.

25.5-5-406. [Formerly 26-4-117] Required features of managed care system.

(1) **General features.** All medicaid managed care programs shall contain the following general features, in addition to others that the state department and the ~~medical services~~ STATE board consider necessary for the effective and cost-efficient operation of those programs:

(a) **Recipient selection of MCOs.** (I) The state department shall, to the extent it determines feasible, provide medicaid-eligible recipients a choice among competing MCOs. MCOs shall provide enrollees a choice among providers within the MCO. Consistent with federal requirements and rules promulgated by the ~~medical services~~ STATE board, the state department is authorized to assign a medicaid recipient to a particular MCO or primary care physician if:

(A) The state department determines that no other MCO or primary care physician has the capacity or expertise necessary to serve the recipient; or

(B) A recipient does not respond within thirty days after the date of a notification of a request for selection of an MCO or primary care physician.

(II) The state department shall inform recipients of the choices available in their area by appropriate sources of information and counseling. This may include an independent, objective facilitator acting under the supervision of the state department. The state department may contract for the facilitator through a competitive bidding process. This function shall ensure that consumers have informed choice among available options to assure the fullest possible voluntary participation in managed care. The state department, in conjunction with the ~~medical services~~ STATE board, shall adopt rules setting forth minimum disclosure requirements for all MCOs. Once a recipient is enrolled in an MCO, the recipient may not change to a different MCO for a period of twelve months; except that the recipient may disenroll without good cause during the first ninety days of enrollment or any time thereafter for good cause as determined by the state department. Good cause shall include but need not be limited to administrative error and an MCO's inability to provide its covered services to a recipient after reasonable efforts on the part of the MCO and the recipient, as defined by the ~~medical services~~ STATE board. Based upon its assessment of any special needs of recipients with cognitive disabilities, the ~~medical services~~ STATE board may adopt rules relating to any necessary good cause provisions for recipients with cognitive disabilities who are assigned to a particular MCO pursuant to subparagraph (I) of this paragraph (a).

(III) When eligible consumers choose to change or disenroll from their selected MCO, the state department shall monitor and gather data about the reasons for disenrolling, including denial of enrollment or disenrollment due to an act or omission of an MCO. The state department shall analyze this data and provide feedback to the plans or providers and shall use the information in the state department's contracting and quality assurance efforts. Persons who have been denied enrollment or have disenrolled due to an act or omission of an MCO may seek review by an independent hearing officer, as provided for and required under federal law and any state statute or ~~regulation~~ RULE.

(b) **Complaints and grievances.** Each MCO shall utilize a complaint and grievance procedure and a process for expedited reviews that comply with ~~regulations~~ RULES established by the state ~~department~~ BOARD. The complaint and grievance procedure shall provide a means by which enrollees may complain about or grieve any action or failure to act that impacts an enrollee's access to, satisfaction with, or the quality of health care services, treatments, or providers. The state department shall establish the position of ombudsman for medicaid managed care. It is the intent of the general assembly that the ombudsman for medicaid managed care be independent from the state department and selected through a competitive bidding process. In the event the state department is unable to contract with an independent ombudsman, an employee of the state department may serve as the ombudsman for medicaid managed care. The ombudsman shall, if the enrollee requests, act as the enrollee's representative in resolving complaints and grievances with the MCO. The process for expedited reviews shall provide a means by which an enrollee may complain and seek resolution concerning any action or failure to act

in an emergency situation that immediately impacts the enrollee's access to quality health care services, treatments, or providers. An enrollee shall be entitled to designate a representative, including but not limited to an attorney, the ombudsman for medicaid managed care, a lay advocate, or the enrollee's physician, to file and pursue a grievance or expedited review on behalf of the enrollee. The procedure shall allow for the unencumbered participation of physicians. An enrollee whose complaint or grievance is not resolved to his or her satisfaction by a procedure described in this paragraph (b) or who chooses to forego a procedure described in this paragraph (b) shall be entitled to request a second-level review by an independent hearing officer, further judicial review, or both, as provided for by federal law and any state statute or ~~regulation~~ **RULE**. The state department may also provide by ~~regulation~~ **RULE** for arbitration as an optional alternative to the complaint and grievance procedure set forth in this paragraph (b) to the extent that such ~~regulations~~ **RULES** do not violate any other state or federal statutory or constitutional requirements.

(c) **Billing medicaid recipients.** Notwithstanding any federal regulations or the general prohibition of section ~~26-4-403~~ 25.5-4-301 against providers billing medicaid recipients, a provider may bill a medicaid recipient who is enrolled with a specific medicaid primary care physician or MCO and, in circumstances defined by the ~~regulations~~ **RULES** of the ~~medical services~~ **STATE** board, receives care from a medical provider outside that organization's network or without referral by the recipient's primary care physician.

(d) **Marketing.** In marketing coverage to medicaid recipients, all MCOs shall comply with all applicable provisions of title 10, C.R.S., regarding health plan marketing. The ~~medical services~~ **STATE** board is authorized to promulgate rules concerning the permissible marketing of medicaid managed care. The purposes of such rules shall include but not be limited to the avoidance of biased selection among the choices available to medicaid recipients.

(e) **Prescription drugs.** All MCOs shall provide prescription drug coverage ~~IN ACCORDANCE WITH THE PROVISIONS OF SECTION 25.5-5-202 (1) (a)~~ as part of a comprehensive health benefit and with respect to any formulary or other access restrictions:

(I) The MCO shall supply participating providers who may prescribe prescription drugs for MCO enrollees with a current copy of such formulary or other access restrictions, including information about coverage, payment, or any requirement for prior authorization; and

(II) The MCO shall provide to all medicaid recipients at periodic intervals, and prior to and during enrollment upon request, clear and concise information about the prescription drug program in language understandable to the medicaid recipients, including information about such formulary or other access restrictions and procedures for gaining access to prescription drugs, including off-formulary products.

(f) **Access to prescription drugs.** (I) The state department shall encourage an MCO to solicit competitive bids for the prescription drug benefit and discourage an MCO from contracting for the prescription drug benefit with a sole source provider

as much as possible. The state department's reports required by section ~~26-4-121~~ 25.5-5-410 shall include a summary of each MCO's pharmacy network by geographic catchment area.

(II) If an MCO solicits competitive bids for the prescription drug benefit, the MCO shall request bids from each pharmacy provider located in the geographic areas in which the MCO is soliciting bids. All MCOs shall follow a reasonable standard for recipient access to prescription drugs. At a minimum, the state department shall verify compliance with these requirements by reviewing evidence provided by the commissioner of insurance concerning compliance with any standards or guidance established by the commissioner of insurance for consumer access to prescription drugs.

(III) The standards and guidance from the insurance commissioner shall be based on the following:

(A) Procedures that an MCO shall follow to ensure that pharmacies in rural communities with fewer than twenty-five thousand persons have the opportunity to join retail prescription drug networks if they agree to reasonable contract terms;

(B) Procedures that an MCO shall follow to notify the pharmacy community of competitively bid prescription drug contracts;

(C) Procedures that an MCO shall follow to give all pharmacies and pharmacy networks a fair opportunity to participate in prescription drug contracts;

(D) Any related matters that are designed to expand consumer access to pharmacy services; and

(E) Any related matters that will enhance the functioning of the free market system with respect to pharmacies.

(IV) Nothing in this paragraph (f) shall apply to the delivery of prescription drug benefits to recipients enrolled in an MCO who are residents of a nursing facility OR TO THE DELIVERY OF MEDICARE PART D PRESCRIPTION DRUGS TO RECIPIENTS WHO ARE ELIGIBLE FOR SUCH DRUGS.

(g) **Continuity of care.** (I) New enrollees, with special needs as defined by the ~~medical services~~ STATE board and as certified by a non-plan physician, may continue to see a non-plan provider for sixty days from the date of enrollment in an MCO, if the enrollee is in an ongoing course of treatment with the previous provider and only if the previous provider agrees:

(A) To accept reimbursement from the MCO as payment in full at rates established by the MCO that shall be no more than the level of reimbursement applicable to similar providers within the MCO's group or network for such services;

(B) To adhere to the MCO's quality assurance requirements and to provide to the MCO necessary medical information related to such care; and

(C) To otherwise adhere to the MCO's policies and procedures including but not limited to procedures regarding referrals, obtaining pre-authorizations, and MCO-approved treatment plans.

(II) New enrollees who are in their second or third trimester of pregnancy may continue to see their practitioner until the completion of post-partum care directly related to the delivery only if the practitioner agrees:

(A) To accept reimbursement from the MCO as payment in full at rates established by the MCO that shall be no more than the level of reimbursement applicable to similar providers within the MCO's group or network for such services;

(B) To adhere to the MCO's quality assurance requirements and to provide to the MCO necessary medical information related to such care; and

(C) To otherwise adhere to the MCO's policies and procedures including but not limited to procedures regarding referrals, obtaining pre-authorizations, and MCO-approved treatment plans.

(III) New enrollees with special needs as defined by the state department may continue to see ancillary providers at the level of care received prior to enrollment for a period of up to seventy-five days. The terms and conditions, including reimbursement rates, shall remain the same as prior to enrollment if the provider and enrollee agree to work in good faith with the MCO toward a transition.

(IV) This paragraph (g) shall not be construed to require an MCO to provide coverage for benefits not otherwise covered.

25.5-5-407. [Formerly 26-4-118] State department recommendations - primary care physician program.

~~(1) Repealed:~~

~~(2)~~ ~~(a)~~ (1) The primary care physician program requires medicaid recipients to select a primary care physician who is solely authorized to provide primary care and referral to all necessary specialty services. To encourage low-cost and accessible care, the state department is authorized to utilize the primary care physician program to deliver services to appropriate medicaid recipients.

~~(b)~~ (2) The state department shall establish procedures and criteria for the cost-effective operation of the primary care physician program, including but not limited to such matters as appropriate eligibility criteria and geographic areas served by the programs.

25.5-5-408. [Formerly 26-4-119] Capitation payments - availability of base data - adjustments - rate calculation - capitation payment proposal - preference - assignment of medicaid recipients. (1) (a) The state department shall make prepaid capitation payment to managed care organizations based upon a defined scope of services.

(b) Except as otherwise provided in paragraph (d) of this subsection (1), under no circumstances, including competitive bidding as set forth in paragraph (c) of this subsection (1), shall the state department pay a capitation payment to an MCO that exceeds ninety-five percent of the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section ~~26-4-118~~ 25.5-5-407. A certification by a qualified actuary retained by the state department shall be conclusive evidence that the state department has correctly calculated the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section ~~26-4-118~~ 25.5-5-407.

(c) Except as otherwise provided in paragraph (d) of this subsection (1) and where the state department has instituted a program of competitive bidding provided in ~~subsection (3) of section 26-4-113~~ 25.5-5-402 (3), the state department may utilize a market rate set through the competitive bid process for a set of defined services. The state department shall only use market rate bids that do not discriminate and are adequate to assure quality and network sufficiency. A certification of a qualified actuary, retained by the state department, to the appropriate lower limit shall be conclusive evidence of the state department's compliance with the requirements of this paragraph (c). For the purposes of this subsection (1), a "qualified actuary" shall be a person deemed as such under ~~regulations~~ RULES promulgated by the commissioner of insurance.

(d) A federally qualified health center, as defined in the federal "Social Security Act", shall be reimbursed by the state department for the total reasonable costs incurred by the center in providing health care services to all recipients of medical assistance.

(2) The state department shall develop capitation rates for MCOs that include risk adjustments, reinsurance, or stop-loss funding methods. Payments to plans may vary when it is shown through diagnoses or other relevant data that certain populations are expected to cost more or less than the capitated population as a whole.

(3) The ~~medical services~~ STATE board, in consultation with recognized medical authorities, shall develop a definition of special needs populations that includes evidence of diagnosed or medically confirmed health conditions. The state department shall develop a method for adjusting payments to plans for such special needs populations when diagnoses or other relevant data indicates these special needs populations would cost significantly more than similarly capitated populations.

~~(4) (Deleted by amendment, L. 2002, p. 833, § 7, effective July 1, 2002.)~~

~~(5)~~ (4) Under no circumstances shall the risk adjustments, reinsurance, or stop-loss methods developed by the state department pursuant to subsection (2) of this section cause the average per capita medicaid payment to a plan to be greater than the projected medicaid expenditures for treating medicaid enrollees of that plan under fee-for-service medicaid.

~~(6)~~ (5) The state department may develop quality incentive payments to recognize superior quality of care or service provided by a managed care plan.

~~(7)~~ (6) Within thirty days from the beginning of each fiscal year, the state department, in cooperation with the MCOs, shall set a timeline for the rate-setting process for the following fiscal year's rates and for the provision of base data to the MCOs that is used in the calculation of the rates, which shall include but not be limited to the information included in subsection ~~(8)~~ (7) of this section.

~~(8)~~ (7) The state department shall identify and make available to the MCOs the base data used in the calculation of the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section ~~26-4-118~~ 25.5-5-407. The state department shall consult with the MCOs regarding any and all adjustments in the base data made to arrive at the capitation payments.

~~(9)~~ (8) For capitation payments effective on and after July 1, 2003, the state department shall recalculate the base calculation every three years. The three-year cycle for the recalculation of the base calculation shall begin with capitation payments effective for fiscal year 2003-04. In the years in which the base calculation is not recalculated, the state department shall annually trend the base calculation after consulting with the MCOs. The state department shall take into consideration when trending the base calculation any public policy changes that affect reimbursement under the "Colorado Medical Assistance Act".

~~(10)~~ (9) The rate-setting process referenced in subsection ~~(7)~~ (6) of this section shall include a time period after the MCOs have received the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section ~~26-4-118~~ 25.5-5-407, for each MCO to submit to the state department the MCO's capitation payment proposal, which shall not exceed ninety-five percent of the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section ~~26-4-118~~ 25.5-5-407. The state department shall provide to the MCOs the MCO's specific adjustments to be included in the calculation of the MCO's proposal. Each MCO's capitation payment proposal shall meet the requirements of section ~~26-4-115 (2) (k) and (k.1)~~ 25.5-5-404 (1) (k) AND (1) (l).

~~(11)~~ (10) For capitation payments effective on and after July 1, 2003, unless otherwise required by federal law, the state department shall certify, through a qualified actuary retained by the state department, that the capitation payments set forth in the contract between the state department and the MCOs comply with all applicable federal and state requirements that govern said capitation payments.

~~(12)~~ (11) Effective on and after July 1, 2003, the capitation payments certified by the qualified actuary under subsection ~~(11)~~ (10) of this section shall not be subject to any dispute resolution process, including any such process set forth in any settlement agreement entered into prior to July 1, 2002.

25.5-5-409. [Formerly 26-4-120] State department - privatization. (1) The general assembly finds that the statewide managed care system is a program under which the private sector has a great deal of experience in making various health care plans available to the private sector and serving as the liaison between large employers and health care providers, including but not limited to health maintenance organizations. The general assembly therefore determines that a statewide managed care system involves duties similar to duties currently or previously performed by state employees but is different in scope and policy objectives from the state medical assistance program.

(2) To that end, pursuant to section 24-50-504 (2) (a), C.R.S., the state department shall enter into personal services contracts that create an independent contractor relationship for the administration of not less than twenty percent of the statewide managed care system. The state department shall enter into personal service contracts for the administration of the managed care system according to the implementation of the statewide managed care system in accordance with section ~~26-4-113~~ 25.5-5-402.

~~(3) Repealed.~~

~~(4)~~ (3) The implementation of this section is contingent upon:

(a) Legislative review of the cost-effectiveness of privatization and the extent to which such privatization enhances the quality of care to recipients; and

(b) A finding by the state personnel director that any of the conditions of section 24-50-504 (2), C.R.S., have been met or that the conditions of section 24-50-503 (1), C.R.S., have been met.

25.5-5-410. [Formerly 26-4-121] Data collection for managed care programs - reports. (1) In addition to any other data collection or reporting requirements set forth in this article AND ARTICLES 4 AND 6 OF THIS TITLE, the state department shall access and compile data concerning health data and outcomes. In addition, no later than July 1, 1998, the state department shall conduct or shall contract with an independent evaluator to conduct a quality assurance analysis of each managed care program in the state for medical assistance recipients. No later than July 1, 1999, and each fiscal year thereafter, the state department, using the compiled data and results from the quality assurance analysis, shall submit a report to the house and senate committees on ~~health, environment, welfare, and institutions~~ HEALTH AND HUMAN SERVICES, OR ANY SUCCESSOR COMMITTEES, on the cost-efficiency of each managed care program or component thereof, with recommendations concerning statewide implementation of the respective programs or components. For the purposes of this subsection (1), "quality assurance" means costs weighed against benefits provided to consumers, health outcomes or maintenance of the individual's highest level of functioning, and the overall change in the health status of the population served. The state department's report shall address capitation, including methods for adjusting rates based on risk allocations, fees-for-services, copayments, chronically ill populations, long-term care, community-supported services, and the entitlement status of medical assistance. The state department's report shall include a comparison of the effectiveness of the MCO program and the primary care physician program based upon common performance standards that shall include

but not be limited to recipient satisfaction.

(2) In addition, the state department of human services, in conjunction with the state department, shall continue its existing efforts, which include obtaining and considering consumer input, to develop managed care systems for the developmentally disabled population and to consider a pilot program for a certificate system to enable the developmentally disabled population to purchase managed care services or fee-for-service care, including long-term care community services. The department of human services shall not implement any managed care system for developmentally disabled services without the express approval of the joint budget committee. Any proposed implementation of fully capitated managed care in the developmental disabilities community service system shall require legislative review.

(3) In addition to any other data collection and reporting requirements, each managed care organization shall submit the following types of data to the state department or its agent:

(a) Medical access;

(b) Consumer outcomes based on statistics maintained on individual consumers as well as the total consumer populations served;

(c) Consumer satisfaction;

(d) Consumer utilization;

(e) Health status of consumers; and

(f) Uncompensated care delivered.

25.5-5-411. [Formerly 26-4-123] Medicaid community mental health services - administration - rules. (1) Except as provided for in subsection (3) of this section, the state department shall administer all medicaid community mental health services for medical assistance recipients including but not limited to the prepaid capitated single entry point system for mental health services, the fee-for-service mental health services, and alternatives to institutionalization. The administration of medicaid community mental health services shall include but shall not be limited to program approval, program monitoring, and data collection.

(2) The state department is authorized to seek federal approval for any necessary changes to the state's waiver that authorizes the statewide system of community mental health care to reflect the provisions of this section. The state department is authorized to limit a recipient's freedom of choice with respect to a provider of mental health services and to restrict reimbursements for mental health services to designated and contracted agencies in such waiver.

(3) The administration of the provision of mental health services to persons receiving services pursuant to *Arevalo v. Colorado Department of Human Services*, Case No. 81 CV 6961, in the district court for the city and county of Denver, and the administration of the mental health institutes shall remain the responsibility of

the department of human services.

(4) On and after April 6, 2004, all positions of employment in the department of human services concerning the powers, duties, and functions of administering all medicaid community mental health services for medical assistance recipients transferred to the state department pursuant to this section and determined to be necessary to carry out the purposes of this section by the executive director of the state department shall be transferred to the state department and shall become employment positions therein.

(5) On and after April 6, 2004, all items of property, real and personal, including office furniture and fixtures, computers and software, books, documents, and records of the department of human services pertaining to the duties and functions of administering all medicaid community mental health services for medical assistance recipients are transferred to the state department and shall become the property thereof.

(6) On and after April 6, 2004, for state fiscal year 2003-04, the state department may bill the department of human services medicaid-funded programs division appropriation within the state department's appropriation for the provision of medicaid community mental health services as authorized in this section.

(7) On or before July 1, 2004, the state department and the department of human services shall jointly produce a document to assist mental health consumers and advocates and providers that participate in Colorado's publicly funded mental health system to understand the respective roles of each department in the provision of mental health services and each department's ability to provide high quality and accessible mental health services. The state department and the department of human services shall make the document available to the public and shall send at least one copy to each community mental health center, statewide mental health advocacy organization, and mental health assessment and services agency. The information contained in the document shall be made available on each department's internet website. The state department and the department of human services are encouraged to consult with representatives of mental health consumer and provider organizations in the development of the document to ensure that it benefits consumers seeking mental health services and consumers who need to express concerns or complaints regarding the quality, availability, or accessibility of mental health services.

(8) When the state auditor conducts an audit of the statewide mental health system, the state auditor shall evaluate the coordination of services between the state department and the department of human services and the impact of the administration of the mental health system on the quality of care within the statewide mental health system.

(9) The state board shall adopt any rules necessary for the implementation of this section. In adopting rules concerning medicaid community mental health services, the state board shall consider the effect the rules may have on the statewide mental health system.

25.5-5-412. [Formerly 26-4-124] Program of all-inclusive care for the elderly

- legislative declaration - services - eligibility. (1) (a) The general assembly hereby finds and declares that it is the intent of this section to replicate the ON LOK program in San Francisco, California, that has proven to be cost-effective at both the state and federal levels. The PACE program is part of a national replication project authorized in section 9412(b)(2) of the federal "Omnibus Budget Reconciliation Act of 1986", as amended, which instructs the secretary of the federal department of health and human services to grant medicare and medicaid waivers to permit not more than ten public or nonprofit private community-based organizations in the country to provide comprehensive health care services on a capitated basis to frail elderly who are at risk of institutionalization. The general assembly finds that, by coordinating an extensive array of medical and nonmedical services, the needs of the participants will be met primarily in an outpatient environment in an adult day health center, in their homes, or in an institutional setting. The general assembly finds that such a service delivery system will enhance the quality of life for the participant and offers the potential to reduce and cap the costs to Colorado of the medical needs of the participants, including hospital and nursing home admissions.

(b) The general assembly finds and declares that the success of the current provider in providing a service delivery system has enhanced the quality of life for many participants in the PACE program and, therefore, the state should develop additional PACE program sites. The general assembly finds that section 4802 of the federal "Balanced Budget Act of 1997", as amended, allows the state to develop additional PACE program sites. The general assembly further finds that new PACE program sites should be developed using the program developed by the current provider as a model. The general assembly also finds that the state should capitalize on the success, experience, and quality of care of such provider in operating the PACE model by utilizing the provider's technical assistance capabilities. Additionally, the general assembly finds that it is necessary to provide technical assistance to new PACE program sites to insure consistent quality of services and ultimate success. The general assembly, therefore, encourages the state department to seek grants and donations from national PACE organizations that have received funding to assist states in PACE expansion initiatives and to secure funding to dedicate a full-time staff person to the implementation of this PACE expansion.

(2) The general assembly has determined on the recommendation of the state department that the PACE program is cost-effective. As a result of such determination and after consultation with the joint budget committee of the general assembly, application has been made to and waivers have been obtained from the federal health care financing administration to implement the PACE program as provided in this section. The general assembly, therefore, authorizes the state department to implement the PACE program in accordance with this section. In connection with the implementation of the program, the state department shall:

(a) Provide a system for reimbursement for services to the PACE program pursuant to this section;

(b) Develop and implement a contract with any nonprofit organization providing the PACE program that sets forth contractual obligations for the PACE program, including but not limited to reporting and monitoring of utilization of services and of the costs of the program as required by the state department;

(c) Acknowledge that it is participating in the national PACE project as initiated by congress;

(d) Be responsible for certifying the eligibility for services of all PACE program participants.

(3) The general assembly declares that the purpose of this section is to provide services that would foster the following goals:

(a) To maintain eligible persons at home as an alternative to long-term institutionalization;

(b) To provide optimum accessibility to various important social and health resources that are available to assist eligible persons in maintaining independent living;

(c) To provide that eligible persons who are frail elderly but who have the capacity to remain in an independent living situation have access to the appropriate social and health services without which independent living would not be possible;

(d) To coordinate, integrate, and link such social and health services by removing obstacles that impede or limit improvements in delivery of these services;

(e) To provide the most efficient and effective use of capitated funds in the delivery of such social and health services;

(f) To assure that capitation payments amount to no more than ninety-five percent of the amount paid under the medicaid fee-for-service structure for an actuarially similar population.

(4) Within the context of the PACE program, the state department may include any or all of the services listed in sections ~~26-4-202, 26-4-203, 26-4-302, and 26-4-303~~, 25.5-5-102, 25.5-5-103, 25.5-5-202, AND 25.5-5-203, as applicable.

(5) An eligible person may elect to receive services from the PACE program as described in subsection (4) of this section. If such an election is made, the eligible person shall not remain eligible for services or payment through the regular medicare or medicaid programs. All services provided by said programs shall be provided through the PACE program in accordance with this section. An eligible person may elect to disenroll from the PACE program at any time.

~~(5.5)~~ (6) The state department, in cooperation with the single entry point agencies established in section ~~26-4-522~~ 25.5-6-106, shall develop and implement a coordinated plan to provide education about PACE program site operations under this section. The state ~~department~~ BOARD shall adopt rules to ensure that case managers and any other appropriate state department staff discuss the option and potential benefits of participating in the PACE program with all eligible long-term care clients. These rules shall require additional and on-going training of the single entry point agency case managers in counties where a PACE program is operating. This training shall be provided by a federally approved PACE provider. In addition, each single entry point agency may designate case managers who have knowledge

about the PACE program.

~~(6)~~ (7) For purposes of this section, "eligible person" means a frail elderly individual who voluntarily enrolls in the PACE program and whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, whose resources do not exceed the limit established by the state department of human services for individuals receiving a mandatory minimum state supplementation of SSI benefits pursuant to section 26-2-204, C.R.S., or in the case of a person who is married, do not exceed the amount authorized in section ~~26-4-506~~ 25.5-6-101, and for whom a physician licensed pursuant to article 36 of title 12, C.R.S., certifies that such a program provides an appropriate alternative to institutionalized care. The term "frail elderly" means an individual who meets functional eligibility requirements, as established by the state department, for nursing home care and who is fifty-five years of age or older.

~~(7)~~ (8) Using a risk-based financing model, any nonprofit organization providing the PACE program shall assume responsibility for all costs generated by PACE program participants, and shall create and maintain a risk reserve fund that will cover any cost overages for any participant. The PACE program is responsible for the entire range of services in the consolidated service model, including hospital and nursing home care, according to participant need as determined by the multidisciplinary team. Any nonprofit organization providing the PACE program is responsible for the full financial risk at the conclusion of the demonstration period and when permanent waivers from the federal health care financing administration are granted. Specific arrangements of the risk-based financing model shall be adopted and negotiated by the federal health care financing administration, any nonprofit organization providing the PACE program, and the state department.

~~(7.5)~~ (9) Nothing in this section requires a PACE program site operator to hold a certificate of authority as a health maintenance organization under part 4 of article 16 of title 10, C.R.S., for purposes of the PACE program.

~~(8) (Deleted by amendment, L. 2002, p. 896, § 1, effective May 31, 2002.)~~

~~(8.5)~~ (10) (a) The state department shall perform a feasibility study, conditioned on the receipt of sufficient gifts, grants, and donations, in order to identify viable communities that may support a PACE program site. This study shall be completed on or before May 1, 2003.

(b) The state department, consistent with the results of the feasibility study, shall use its best efforts to have in operation:

(I) One additional PACE program site by July 1, 2004;

(II) A total of four additional PACE program sites by July 1, 2005; and

(III) A total of six additional PACE program sites by July 1, 2006.

(c) (I) No later than May 30, 2003, the executive director of the state department shall submit to the joint budget committee of the general assembly and to the ~~health, environment, welfare, and institutions~~ HEALTH AND HUMAN SERVICES committees

of the house of representatives and the senate, OR ANY SUCCESSOR COMMITTEES, a written report of the results of the feasibility study conducted under paragraph (a) of this subsection ~~(8.5)~~ (10).

(II) No later than January 1, 2007, the executive director of the state department shall submit to the joint budget committee of the general assembly and to the ~~health, environment, welfare, and institutions committees~~ HEALTH AND HUMAN SERVICES COMMITTEES of the house of representatives and the senate, OR ANY SUCCESSOR COMMITTEES, a final written report detailing the expansion of PACE program sites across the state.

~~(9)~~ (11) The ~~medical services~~ STATE board shall promulgate such rules, pursuant to article 4 of title 24, C.R.S., as are necessary to implement this section.

~~(10)~~ (12) The general assembly shall make appropriations to the state department to fund services under this section provided at a monthly capitated rate. The state department shall annually renegotiate a monthly capitated rate for the contracted services based on the ninety-five percent of the medicaid fee-for-service costs of an actuarially similar population.

~~(11)~~ (13) The state department may accept grants and donations from private sources for the purpose of implementing this section.

25.5-5-413. [Formerly 26-4-127] Direct contracting with providers - legislative declaration. (1) The general assembly hereby finds, determines, and declares that costs associated with providing medical assistance to recipients have increased substantially due in part to increased costs of health care services and higher utilization rates. These cost pressures have been most dramatically demonstrated in the southern area of the state. Therefore, the general assembly finds, determines, and declares that pilot programs should be created to evaluate whether a provider may contract directly with the state department for the provision of services to recipients.

(2) ~~(a)~~ The state department is authorized to contract directly with any provider who is able to demonstrate compliance with state laws and ~~regulations~~ RULES pertaining to risk-bearing entities to provide a capitated-risk program on a per member per month basis. The provider shall not serve more than two thousand five hundred recipients. The provider shall accept full risk for each participant, except for transplants or out-of-area services.

~~(b) If the state department implements direct contracting with a provider pursuant to this section, the provider and the state department shall report to the health, environment, welfare, and institutions committees of the house of representatives and the senate no later than July 1, 2003, on the status of direct contracting. The report shall include an analysis of the effectiveness of direct contracting and whether the direct contracting should be continued to the same or larger numbers of recipients.~~

~~(2.5)~~ (3) The state department is authorized to contract directly with any provider who is able to provide a cost-effective and quality health care system through a capitated partial risk program on a per member per month basis or through any other

financial arrangement with the department where the provider manages the health care available to the recipients and shares with the state department the savings associated with management of such health care.

~~(3)~~ (4) **Selection of the provider.** The state department shall select any provider who:

- (a) Is able to provide evidence of a successful history of risk management for recipients;
- (b) Initiates direct contracting with the state department; and
- (c) Is able to demonstrate compliance with state laws and ~~regulations~~ RULES pertaining to risk-bearing entities.

25.5-5-414. [Formerly 26-4-421] Telemedicine - legislative intent. (1) It is the intent of the general assembly to recognize the practice of telemedicine as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with a provider.

(2) For the purposes of this section, "telemedicine" shall have the same meaning as set forth in section 12-36-106 (1) (g), C.R.S.

(3) On or after January 1, 2002, face-to-face contact between a health care provider and a patient in a county with one hundred fifty thousand residents or less may not be required under the managed care system created in ~~part 1 of this article~~ THIS PART 4 for services appropriately provided through telemedicine, subject to reimbursement policies developed by the STATE department of ~~health care policy and financing~~ to compensate providers who provide health care services covered by the program created in section ~~26-4-104~~ 25.5-4-104. Telemedicine services may only be used in areas of the state where the technology necessary for the provision of telemedicine exists. The audio and visual telemedicine system used shall, at a minimum, have the capability to meet the procedural definition of the most recent edition of the current procedural terminology that represents the service provided through telemedicine. The telecommunications equipment shall be of a level of quality to adequately complete all necessary components to document the level of service for the current procedural terminology fourth edition codes that are billed. If a peripheral diagnostic scope is required to assess the patient, it shall provide adequate resolution or audio quality for decision making.

(4) The STATE department of ~~health care policy and financing~~ shall report to the ~~health, environment, welfare, and institutions~~ HEALTH AND HUMAN SERVICES committees of the house of representatives and the senate, OR ANY SUCCESSOR COMMITTEES, no later than January 1, 2006, on the application of telemedicine to provide home health care; emergency care; critical and intensive care, including, but not limited to, neonatal care; psychiatric evaluation; psychotherapy; and medical management as potential managed care system benefits. Such report shall take into account the availability of technology as of the time of the report to use telemedicine for home health care, emergency care, and critical and intensive care and the availability of broadband access within the state.

(5) The managed care system shall not be required to pay for consultation provided by a provider by telephone or facsimile machines.

(6) The STATE department ~~of health care policy and financing~~ may accept and expend gifts, grants, and donations from any source to conduct the valuation of the cost-effectiveness and quality of health care provided through telemedicine by those providers who are reimbursed for telemedicine services by the managed care system.

PART 5 PRESCRIPTION DRUGS

25.5-5-501. [Formerly 26-4-406] Providers - drug reimbursement.

(1) (a) As to drugs for which payment is made, the state board's rules for the payment therefor shall include the requirement that the generic equivalent of a brand-name drug be prescribed if the generic equivalent is a therapeutic equivalent to the brand-name drug, except when reimbursement to the state for a brand-name drug makes the brand-name drug less expensive than the cost of the generic equivalent. The state department shall grant an exception to this requirement if the patient has been stabilized on a medication and the treating physician, or a pharmacist with the concurrence of the treating physician, is of the opinion that a transition to the generic equivalent of the brand-name drug would be unacceptably disruptive. The requirements of this subsection (1) shall not apply to medications for the treatment of biologically based mental illness, as defined in section 10-16-104 (5.5), C.R.S., the treatment of cancer, the treatment of epilepsy, or the treatment of human immunodeficiency virus and acquired immune deficiency syndrome.

(b) The provisions of this subsection (1) shall apply to fee-for-service and primary care physician program recipients.

(2) It is the general assembly's intent that requiring the use of a generic equivalent of a brand-name drug will produce savings within the state's medicaid program. The state department, therefore, is authorized to use savings in the medical services premiums appropriations to fund the administrative review process required by subsection (1) of this section.

25.5-5-502. [Formerly 26-4-406.3] Unused medications - reuse - rules.

(1) As used in this section, unless the context otherwise requires, "medication" means prescription medication that is not a controlled substance.

(2) A pharmacist participating in the medical assistance program may accept unused medication from a licensed facility, as defined in section 12-22-133, C.R.S., or a licensed health care provider for the purpose of dispensing the medication to another person. A pharmacist shall reimburse the state department for the cost of medications that the state department has paid to the pharmacist if medications are returned to a pharmacist and the medications are available to be dispensed to another person. Medications shall only be available to be dispensed to another person under this section if the medications are:

(a) Liquid and the vial is still sealed and properly stored;

- (b) Individually packaged and the packaging has not been damaged; or
- (c) In the original, unopened, sealed, and tamper-evident unit dose packaging.

(3) Medication dispensed pursuant to this section shall bear an expiration date that is later than six months after the date the drug was donated.

(4) Any savings realized through reimbursements received pursuant to subsection (1) of this section shall fund the administration of this section.

(5) The state board, in consultation with the state board of pharmacy, shall adopt rules for the implementation of this section.

25.5-5-503. [Formerly 26-4-406.5] Prescription drug benefits - authorization - dual-eligible participation. (1) The state department is authorized to ensure the participation of Colorado medical assistance recipients, who are also eligible for medicare, in any federal prescription drug benefit enacted for medicare recipients.

(2) Prescribed drugs shall not be a covered benefit under the medical assistance program for a recipient who is enrolled in a prescription drug benefit program under medicare; except that, if a prescribed drug is not a covered Part D drug as defined in the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003", P.L. 108-173, the prescribed drug may be a covered benefit if it is otherwise covered under the medical assistance program and federal financial participation is available.

25.5-5-504. [Formerly 26-4-407] Providers of pharmaceutical services. (1) Consistent with the provisions of section ~~26-4-404~~ 25.5-4-401 (1), and consistent with subsections (2) and (3) of this section, and subject to available appropriations, no provider of pharmaceutical services who meets the conditions imposed by this article AND ARTICLES 4 AND 6 OF THIS TITLE and who complies with the terms and conditions established by the state department and contracting health maintenance organizations and prepaid health plans shall be excluded from contracting for the provision of pharmaceutical services to recipients authorized in this article AND ARTICLES 4 AND 6 OF THIS TITLE.

(2) This provision shall not apply to a health maintenance organization or prepaid health plan that enrolls less than forty percent of all the resident medicaid recipients in any county with over one thousand medicaid recipients.

(3) The ~~medical services~~ STATE board shall establish specifications in rules in order to provide criteria to health maintenance organizations and prepaid health plans which ensure the accessibility and quality of service to clients and the terms and conditions for pharmaceutical contracts.

25.5-5-505. [Formerly 26-4-407.5] Prescribed drugs - mail order. (1) The state board shall adopt by rule a system to allow medical assistance recipients who suffer from a physical hardship that prohibits the recipient from obtaining prescription medications from a local pharmacy to receive prescribed maintenance medications through mail order. The state board shall include in the rules the definition of maintenance medications. The rules may allow for a medical assistance recipient, who qualifies to receive medication through mail order

pursuant to this section, to receive up to a three-month supply, or the maximum allowed under federal law, of maintenance medications used to treat chronic medical conditions. The state board shall, to the extent possible, require the use of local pharmacies that are able to provide the same services as mail order. To the extent allowed by federal law, the state department shall require that the same copayment amount be paid by a medical assistance recipient receiving prescription medication through mail order as a medical assistance recipient receiving prescription medication from a local pharmacy.

(2) The state department shall seek any federal authorization necessary to implement this section.

25.5-5-506. [Formerly 26-4-408] Prescribed drugs - utilization review.

(1) The state department shall develop and implement a drug utilization review process to assure the appropriate utilization of drugs by patients receiving medical assistance in the fee-for-service and primary care physician programs. The review process shall include the monitoring of prescription information and shall address at a minimum underutilization and overutilization of benefit drugs. Periodic reports of findings and recommendations shall be forwarded to the state department.

~~(1.5)~~ (2) It is the general assembly's intent that the implementation of a drug utilization review process for the fee-for-service and primary care physician programs will produce savings within the state's medicaid program. The state department, therefore, is authorized to use savings in the medical services premiums appropriations to fund the development and implementation of a drug utilization review process for these programs, as required by subsection (1) of this section. The state department may contract on a contingency basis for the development or implementation of the review process required by subsection (1) of this section.

~~(2) Repealed.~~

(3) (a) The state department shall implement drug utilization mechanisms, including, but not limited to, prior authorization, to control costs in the medical assistance program associated with prescribed drugs. The state board shall promulgate a rule that outlines a process in which any interested party may be notified of and comment on the implementation of any prior authorization for a class of prescribed drugs before the class is prior authorized.

(b) The state department shall report to the ~~health, environment, welfare, and institutions~~ HEALTH AND HUMAN SERVICES committees for the house of representatives and the senate, OR ANY SUCCESSOR COMMITTEES, and the joint budget committee no later than December 1, 2003, and each December 1 thereafter, on plan utilization mechanisms that have been implemented or that will be implemented by the state department, the time frames for implementation, the expected savings associated with each utilization mechanism, and any other information deemed appropriate by the ~~health, environment, welfare, and institutions~~ HEALTH AND HUMAN SERVICES COMMITTEES, OR ANY SUCCESSOR COMMITTEES, or the joint budget committee.

ARTICLE 6
Colorado Medical Assistance Act

Long-term Care**PART 1
LONG-TERM CARE ADMINISTRATION**

25.5-6-101. [Formerly 26-4-506] Spousal protection - protection of income and resources for community spouse - definitions - amounts retained - responsibility of state department - right to appeal. (1) As used in this section, unless the context otherwise requires:

(a) "Community spouse" means the spouse of a person who is in an institution or nursing facility, the spouse of a person who is enrolled in the PACE program authorized pursuant to section ~~26-4-124~~ 25.5-5-412, OR the spouse of a person who is receiving home- and community-based services pursuant to ~~part 6 of this article.~~ ~~or the spouse of a person who is receiving equivalent services under the integrated care and financing project authorized pursuant to section 26-4-122.~~

(b) "Community spouse monthly income allowance" means the amount by which the minimum monthly maintenance needs allowance exceeds the amount of monthly income ~~which~~ THAT is available to the community spouse.

(c) "Community spouse resource allowance" means the amount of assets, excluding the value of the home and other exempt resources under federal law, ~~which~~ THAT the community spouse shall be allowed to retain and ~~which~~ THAT shall not be available to cover an institutionalized spouse's cost of care.

(d) (I) "Institutionalized spouse" means an individual who is in an institution or nursing facility who is married to a spouse who is not in an institution or nursing facility.

(II) For purposes of this section, "institutionalized spouse" includes an individual who is enrolled in the PACE program authorized pursuant to section ~~26-4-124~~ 25.5-5-412 or is receiving home- and community-based services pursuant to ~~part 6 of this article, or is receiving equivalent services under the integrated care and financing project authorized pursuant to section 26-4-122~~ and who is married to a spouse who is not enrolled in the PACE program or receiving home- and community-based services. ~~or receiving equivalent services under the integrated care and financing project authorized pursuant to section 26-4-122.~~

(e) (I) (A) "Minimum monthly maintenance needs allowance" means an amount which is equal to an applicable percent of the nonfarm income official poverty line (increased annually by the consumer price index for all urban consumers), as defined by the federal office of management and budget, for a family unit of two members.

(B) For the purposes of sub-subparagraph (A) of this subparagraph (I), the applicable percent shall be: As of September 30, 1989, one hundred twenty-two percent; as of July 1, 1991, one hundred thirty-three percent; as of July 1, 1992, one hundred fifty percent.

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (e), the

minimum monthly maintenance needs allowance may be increased on an individual basis if:

(A) The community spouse has shelter and utilities expenses that exceed thirty percent of the minimum monthly maintenance needs allowance; except that the total allowance shall not exceed fifteen hundred dollars (increased annually by the consumer price index for all urban consumers);

(B) Either spouse is responsible for a dependent family member, including children, parents, or siblings who reside with the community spouse; or

(C) The community spouse has exceptional circumstances which would result in significant financial duress.

(2) (a) In order to implement the medical assistance program in compliance with the federal "Medicare Catastrophic Coverage Act of 1988", as amended, the state department shall ensure, when an institutionalized spouse is eligible for medical assistance under this article AND ARTICLES 4 AND 5 OF THIS TITLE, that the community spouse retain a community spouse monthly income allowance but only to the extent that income of the institutionalized spouse is made available to the community spouse.

(b) (I) The resources available to the married couple shall be calculated at the beginning of a continuous period of institutionalization of the institutionalized spouse. The community spouse shall retain the remainder of the couple's countable resources up to the federal maximum resource allowance as a community spouse resources allowance. The institutionalized spouse may keep an amount up to the amount of resources allowed under the federal medicaid program.

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (b), if either spouse establishes that the community spouse resource allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, an amount adequate to provide the minimum monthly maintenance needs allowance shall be substituted.

(3) The state ~~department~~ BOARD shall have the authority to promulgate any rules ~~and regulations which~~ THAT are necessary to implement the provisions of this section in accordance with the federal "Medicare Catastrophic Coverage Act of 1988", as amended. The rules adopted by the state ~~department~~ BOARD shall include, as a minimum, provisions regarding the following matters:

(a) The treatment of a married couple's income and resources before and after eligibility for medical assistance is established, including the basis for dividing such income and resources between the two parties;

(b) The process for appealing any determinations regarding income and resources ~~which~~ THAT are made pursuant to these rules. ~~and regulations.~~

25.5-6-102. [Formerly 26-4-506.5] Court-approved trusts - transfer of property for persons seeking medical assistance for nursing home care - undue hardship - legislative declaration. (1) The general assembly hereby finds,

determines, and declares that:

(a) The state makes significant expenditures for nursing home care under the "Colorado Medical Assistance Act";

(b) A large number of persons do not have enough income to afford nursing home care, but have too much income to qualify for state medical assistance, a situation popularly referred to as the "Utah gap";

(c) Some persons in the Utah gap, through innovative court-approved trust arrangements, have become qualified for state medical assistance, thereby increasing state medical assistance expenditures;

(d) It is therefore appropriate to enact state laws which limit such court-approved trusts in a manner that is consistent with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396 et seq., as amended, and which provide that persons who qualify for assistance as a result of the creation of such trusts shall be treated the same as any other recipient of medical assistance for nursing home care;

(e) In enacting this section, the general assembly intends only to limit certain court-approved trusts and court-approved transfers of property. It is not the general assembly's intent to approve or disapprove of privately created trusts or private transfers of property made under the same or similar circumstances.

(2) The county department shall verify that an applicant for medical assistance for nursing home care, pursuant to the provisions of this title, meets applicable eligibility criteria for assistance other than those set forth in subsection (3) of this section. Upon verification, for eligibility purposes and in accordance with subsection (3) of this section, the county department shall make a determination of the status of any court-approved trust established for or court-approved transfer of property made by or for the applicant.

(3) (a) If a person who applies for medical assistance for nursing home care would be deemed ineligible for assistance as a result of deeming a court-approved trust established for the applicant as a medicaid qualifying trust or as a result of deeming property in the court-approved trust as an improper transfer of assets, the person's application shall, nonetheless, be treated as a case of undue hardship and the person shall be eligible for medical assistance for said care if the establishment of the court-approved trust meets the following criteria:

(I) The applicant's monthly gross income from all sources, without reference to the court-approved trust, exceeds the income eligibility standard for medical assistance then in effect but is less than the average private pay rate for nursing home care for the geographic region in which the applicant lives;

(II) The property used to fund the trust shall be limited to monthly unearned income owned by the applicant, including any pension payment;

(III) The applicant and the state medical assistance program shall be the sole beneficiaries of the trust. The entire corpus of the trust, or as much of the corpus as may be distributed each month without violating federal requirements for federal

financial participation, shall be distributed each month for expenses related to the beneficiary's nursing home care that are approved under the medical assistance program; except that an amount reasonably necessary to maintain the existence of the trust and to comply with federal requirements may be retained in the trust. Deductions may be distributed from the trust to the same extent deductions from the income of a nursing home resident who is not a trust beneficiary are allowed under the medical assistance program, which shall include the following:

(A) A monthly personal needs allowance;

(B) Payments to the beneficiary's community spouse or dependent family members as provided and in accordance with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396r-5, as amended, and section ~~26-4-506~~ 25.5-6-101;

(C) Specified health insurance costs and special medical services provided under Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396a(r), as amended; and

(D) Any other deduction provided in the rules of the state department. ~~of health care policy and financing;~~

(IV) Upon the death of the beneficiary, a remainder interest in the corpus of the trust shall pass to the state agency responsible for administering the state medical assistance program;

(V) The trust shall not be subject to modification by the beneficiary or the trustee unless otherwise provided by this section or section 15-14-412.5, C.R.S.

(b) For the purposes of this subsection (3), "medicaid qualifying trust" shall have the same meaning as set forth in Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396a(k).

(4) The state ~~department~~ BOARD shall adopt rules as are necessary for the implementation of this section and as are necessary to comply with federal law. In addition, the state department shall amend the state medical assistance plan in a manner that is consistent with the provisions of this section.

(5) This section shall take effect January 1, 1992, and shall apply to any court-approved trust established for or court-approved transfer of property made by or for a protected person applying for or receiving medical assistance for nursing home care pursuant to the provisions of this title, on or after said date; except that a court-approved trust created before said date ~~which~~ THAT does not comply with this section shall be modified to comply with this section no later than July 1, 1992, before which time the court-approved trust or court-approved transfer of property to a trust shall not render the protected person ineligible for medical assistance.

(6) The provisions of this section shall not apply if federal funds are not available for persons who would qualify for medical assistance as a result of a court-approved trust that meets the criteria set forth in this section.

(7) This section shall apply to trusts established or transfers of property made prior to July 1, 1994. The provisions set forth in sections 15-14-412.6 to 15-14-412.9, C.R.S., and any rules adopted by the ~~medical services~~ STATE board pursuant to section ~~26-4-506.6~~ 25.5-6-103 shall apply to trusts established or property transferred on or after that date.

25.5-6-103. [Formerly 26-4-506.6] Court-approved trust - transfer of property for persons seeking medical assistance - rule-making authority for trusts created on or after July 1, 1994 - undue hardship. (1) The ~~medical services~~ STATE board shall adopt such rules as are necessary with respect to trusts established pursuant to sections 15-14-412.6 to 15-14-412.9, C.R.S. The ~~medical services~~ STATE board shall adopt rules that address, but need not be limited to, the following:

(a) The definition, including any limitations, of permissible distributions from trusts, taking federal guidelines into consideration;

(b) Reasonable financial reimbursement or incentives to the STATE department, ~~of health care policy and financing~~, county departments of social services, and any other designated agencies for the efforts and expenses in monitoring trusts, and where necessary, for the recovery of trust property that has been improperly distributed or otherwise expended.

(2) The ~~medical services~~ STATE board shall comply with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396p (d) (5), as amended, which requires the state medicaid agency to establish procedures, in accordance with standards specified by the secretary of the United States department of health and human services, under which the state medicaid agency may waive the application of the general rules for considering trust property in determining eligibility for medical assistance if the applicant for medical assistance establishes that the application of the general rules would work an undue hardship on the individual.

(3) The STATE department shall determine the feasibility of providing ongoing support of dependents by using the trust corpus during the life of the person for whom a trust is created or using the remainder of the trust after the death of the person for whom the trust was created. If the STATE department determines that it is feasible to provide that support, the STATE department shall seek a waiver from the federal ~~health care financing administration~~ GOVERNMENT to permit the use of trust property for that purpose.

25.5-6-104. [Formerly 26-4-507] Long-term care placements - comprehensive and uniform client assessment instrument - long-term care access study - legislative declaration - definitions. (1) (a) The general assembly hereby finds, determines, and declares that there is an increasing strain on long-term care services in the state; that the number of persons in need of long-term care continues to grow; that community-based resources are not integrated into a centralized system for referrals, assessment of needs, development of care plans, and case management; and that persons in need of long-term care services have difficulty accessing and using the current system, which is fragmented and which results in inappropriate placements.

(b) The general assembly further finds, determines, and declares that the state is in need of a long-term care system that organizes each long-term care client's entry, assessment of need, and service delivery into a single unified system; and that such system must include, at a minimum, a locally established single entry point administered by a designated entity, a single client assessment instrument and administrative process, targeted case management in order to maximize existing federal, state, and local funding, case management, and an accountability mechanism designed to assure that budget allocations are being effectively managed.

(c) The general assembly therefore concludes that it is appropriate to develop and implement a comprehensive and uniform long-term care client assessment process and to study the establishment of a single entry point system that provides for the coordination of access and service delivery to long-term care clients at the local level, that is available to all persons in need of long-term care, and that is well managed and cost-efficient.

(2) As used in this section and in sections ~~26-4-521 to 26-4-525~~ 25.5-6-105 TO 25.5-6-107, unless the context otherwise requires:

(a) "Activities of daily living" means the basic self-care activities, including eating, bathing, dressing, transferring from bed to chair, bowel and bladder control, and independent ambulation.

(b) "Case management services" means the assessment of a long-term care client's needs, the development and implementation of a care plan for such client, the coordination and monitoring of long-term care service delivery, the direct delivery of services as provided by this article or by rules adopted by the ~~medical services~~ STATE board pursuant to this article, the evaluation of service effectiveness, and the reassessment of such client's needs, all of which shall be performed by a single entry point as defined in paragraph (k) of this subsection (2).

(c) "Community-based" means services provided in an individual's home or in a homelike setting. "Community-based" does not include a hospital, hospital unit, nursing facility, or nursing home.

(d) "Comprehensive and uniform client assessment process" means a standard procedure, which includes the use of a uniform assessment instrument, to measure a client's functional capacity, to determine the social and medical needs of a current or potential client of any long-term care program, and to target resources to the functionally impaired.

(e) "Continuum of care" means an organized system of long-term care, benefits, and services to which a client has access and which enables a client to move from one level or type of care to another without encountering gaps in or barriers to service.

(f) "Information and referral" means the provision of specific, accurate, and timely public information about services available to aging and disabled adults in need of long-term care and referral to alternative agencies, programs, and services based on client inquiries.

(g) "Instrumental activities of daily living" means home management and independent living activities such as cooking, cleaning, using a telephone, shopping, doing laundry, providing transportation, and managing money.

(h) "Long-term care" means those services designed to provide diagnostic, preventive, therapeutic, rehabilitative, supportive, and maintenance services for individuals who have chronic physical or mental impairments, or both, in a variety of institutional and noninstitutional settings, including the home, with the goal of promoting the optimum level of physical, social, and psychological functioning of the individuals.

(i) "Resource development" means the study, establishment, and implementation of additional resources or services which will extend the capabilities of community long-term care systems to better serve long-term care clients.

(j) "Screening" means a preliminary determination of need for long-term care services and, on the basis of such determination, the making of an appropriate referral for a client assessment in accordance with subsection (3) of this section or referral to another community resource to assist clients who are not in need of long-term care services.

(k) "Single entry point" means the availability of a single access or entry point within a local area where a current or potential long-term care client can obtain long-term care information, screening, assessment of need, and referral to appropriate long-term care program and case management services.

(3) (a) On or before July 1, 1991, the state department shall establish, by rule ~~and regulation~~ in accordance with article 4 of title 24, C.R.S., a comprehensive and uniform client assessment process for all individuals in need of long-term care, the purpose of which is to determine the appropriate services and levels of care necessary to meet clients' needs, to analyze alternative forms of care and the payment sources for such care, and to assist in the selection of long-term care programs and services that meet clients' needs most cost-efficiently.

(b) Participation in the process shall be mandatory for clients of publicly funded long-term care programs, including, but not limited to, the following:

(I) Nursing facilities;

(II) Home- and community-based services for the elderly, the blind, and the disabled;

(III) Alternative care facilities;

(IV) Home care allowance;

(V) Adult foster care;

(VI) In-home services under the federal "Older Americans Act of 1965", as amended, 42 U.S.C. sec. 3001;

(VII) Home health services for long-term care clients;

(VIII) Home- and community-based services for persons living with acquired immune deficiency syndrome (AIDS).

(c) Private paying clients of long-term care programs may participate in the process for a fee to be established by the state department and adopted through rules, ~~and regulations~~.

(d) The state department, through rules, ~~and regulations~~, shall develop and implement no later than July 1, 1991, a uniform long-term care client needs assessment instrument for all individuals needing long-term care. The instrument shall be used as part of the comprehensive and uniform client assessment process to be established in accordance with paragraph (a) of this subsection (3) and shall serve the following functions:

(I) To obtain information on each client's status in the following areas:

(A) Activities of daily living and instrumental activities of daily living;

(B) Physical health;

(C) Cognitive and emotional well-being;

(D) Social interaction and current support resources;

(II) To assess each client's physical environment in terms of meeting the client's needs;

(III) To obtain information on each client's payment sources, including obtaining financial eligibility information for publicly funded long-term care programs;

(IV) To disclose the need for more intensive needs assessments in areas such as nutrition, adult protection, dementia, and mental health;

(V) To prioritize a client's need for care using criteria established by the state department for specific publicly funded long-term care programs;

(VI) To serve as the functional assessment for the determinations of medical necessity.

(e) On and after July 1, 1991, no publicly funded client shall be placed in a long-term care program unless such placement is in accordance with rules ~~and regulations~~ adopted by the state ~~department~~ BOARD in implementing this section.

25.5-6-105. [Formerly 26-4-521] Legislative declaration relating to implementation of single entry point system. (1) The general assembly hereby finds, determines, and declares that:

(a) A study of a single entry point system in accordance with former section 26-4.5-404, C.R.S., has been completed;

(b) The establishment of a single entry point system for the coordination of access to existing services and service delivery for all long-term care clients at the local level can be implemented in a cost-efficient manner;

(c) The implementation of a well-managed single entry point system will result in the utilization of more appropriate services by long-term care clients over time and will provide better information on the unmet service needs of clients; and

(d) The implementation of a statewide single entry point system is a comprehensive undertaking and would be more conducive to a phased-in approach.

(2) The general assembly further finds, determines, and declares that it is appropriate to develop and implement, through four phases, a single entry point system for the state and, therefore, enacts sections 26-4-522 to 26-4-525, WHICH WERE RELOCATED TO SECTIONS 25.5-6-106 AND 25.5-6-107, RESPECTIVELY, IN THE 2006 RECODIFICATION OF THIS TITLE, to provide for such development and implementation.

25.5-6-106. [Formerly 26-4-522] Single entry point system - authorization - phases for implementation - services provided. (1) **Authorization.** The ~~medical services~~ STATE board is hereby authorized to adopt rules providing for the establishment of a single entry point system that consists of single entry point agencies throughout the state for the purpose of enabling persons eighteen years of age or older in need of long-term care to access appropriate long-term care services.

~~(2) Repealed.~~

~~(2)~~ (2) **Single entry point agencies - service programs - functions.** (a) A single entry point agency shall be an agency in a local community through which any person eighteen years of age or older who is in need of long-term care can access needed long-term care services. A single entry point agency may be a private, nonprofit organization, a county agency, including a county department of social services, a county nursing service, an area agency on aging, or a multicounty agency. Persons in need of specialized assistance such as services for developmental disabilities or mental illness may be referred by a single entry point agency to programs under the department of human services.

(b) The agency may serve private paying clients on a fee-for-service basis and shall serve clients of publicly funded long-term care programs, including, but not limited to, the following:

(I) Nursing facility care;

(II) Home- and community-based services for the elderly, blind, and disabled;

(III) Home- and community-based services for persons living with acquired immune deficiency syndrome;

(IV) Long-term home health care;

(V) Home care allowance;

(VI) Alternative care facilities;

(VII) Adult foster care;

(VIII) Certain in-home services available pursuant to the federal "Older Americans Act of 1965", as amended; and

(IX) Home- and community-based services for persons with brain injury.

(c) The major functions of a single entry point shall include, but need not be limited to, the following:

(I) Providing information;

(II) Screening and referral services;

(III) Assessing clients' needs in accordance with section ~~26-4-507~~ 25.5-6-104;

(IV) Developing plans of care for clients;

(V) Determining payment sources available to clients for long-term care services;

(VI) Authorizing the provision of certain long-term care services, as designated by the state department;

(VII) Determining eligibility for certain long-term care programs, as designated by the state department;

(VIII) Delivering case management services as an administrative function;

(IX) Targeting outreach efforts to those most at risk of institutionalization;

(X) Identifying resource gaps and coordinating resource development;

(XI) Recovering overpayment of benefits in accordance with rules adopted by the ~~medical services~~ STATE board;

(XII) Maintaining fiscal accountability; and

(XIII) Rendering state certified services, as provided by ~~medical services~~ STATE board rules, as a qualified and state certified agency.

~~(4)~~ **(3) State certification of a single entry point agency - quality assurance standards.** (a) Upon selection of a single entry point agency, ~~in accordance with subsection (2) of this section~~ the state department shall contract with an agency for five years but shall recertify the agency annually based on an evaluation procedure provided for in paragraph (b) of this subsection ~~(4)~~ (3).

(b) The ~~medical services~~ STATE board shall adopt rules for the establishment of a quality assurance program for the purpose of monitoring the quality of services provided to clients and for recertifying single entry point agencies. The rules shall

provide for: Procedures to evaluate the quality of services provided by the agency; an assessment of the agency's compliance with program requirements, including compliance with case management standards, which standards shall be adopted by the state department; an assessment of an agency's performance of administrative functions, including reasonable costs per client, timely responses, managing programs in one consolidated unit, on-site visits to clients, community coordination and outreach, and client monitoring; a determination as to whether targeted populations are being identified and served; and an evaluation concerning financial accountability.

(c) The state department shall monitor each single entry point agency in the state for compliance with quality assurance standards adopted by the state and may provide for the implementation of sanctions at any time for noncompliance. In addition, each county department may enter into cooperative agreements or contracts with the single entry point agencies to assure quality performance by the single entry point agency serving such county.

(d) Ongoing reimbursement to single entry points shall be contingent upon compliance with quality assurance standards.

25.5-6-107. [Formerly 26-4-525] Financing of single entry point system.

(1) The single entry point system shall be financed with the following moneys:

(a) Federal financial participation moneys available for case management for home- and community-based services pursuant to ~~part 6 of~~ this article, and for administration of medical assistance programs, pursuant to Title XIX of the federal "Social Security Act", as amended;

(b) The state's share or contribution for specific long-term care programs in accordance with or pursuant to sections 26-1-122 and 26-2-114, C.R.S.;

(c) County contributions, as follows:

(I) The total for the fiscal year beginning July 1, 1990, and for each fiscal year thereafter, which totals shall serve as the base for determining the contribution required in subparagraph (II) of this paragraph (c), of the following: The counties' five percent contribution for home care allowance and adult foster care services as required by section 26-1-122, C.R.S.

(II) The amount contributed from each county in accordance with subparagraph (I) of this paragraph (c) after making an adjustment based on the percentage of an increase or decrease per fiscal year in the service costs for clients of such county. However, in no case shall a county be required under this subparagraph (II) to contribute more than a five percent increase in said service costs.

(2) County contributions for client services made in accordance with subparagraph (I) of paragraph (c) of subsection (1) of this section shall be expended only for clients of the county providing said contribution.

25.5-6-108. [Formerly 26-4-425] Legislative declaration - advisory committee - long-term care - report - repeal. (1) Legislative declaration.

(a) The general assembly hereby finds that:

(I) It is concerned that the community long-term care system is not prepared for the ensuing service demand that will be experienced as a result of the explosion of "baby boomers" that will need services in the near future;

(II) The community long-term care system is antiquated, outdated, and unable to respond efficiently and effectively to accommodate a range of services necessary to address the needs of this growing population;

(III) The state needs to provide effective and efficient delivery systems designed to provide better access, consumer choice, economy, and congruence of a quality of life in the least restrictive setting to medicaid recipients now and in the future; and

(IV) The state has an urgent need to create a community long-term care system prepared to address the needs of clients, provide the maximum service delivery, and make the best use of available public funds.

(b) The general assembly, therefore, declares that it is in the state's best interests to create an advisory committee to explore and recommend to the state department public policy that will enable the state's medicaid program to act strategically as a client advocate and be an efficient and effective purchaser of services and service delivery.

(2) **Advisory committee.** Contingent on the condition specified in subsection (6) of this section, the state department shall convene an advisory committee no later than August 15, 2005, to assist in the creation of a community long-term care delivery system that will provide an opportunity for excellence in management and that fosters a continuum of community long-term care services and service delivery. The state department shall hire an independent facilitator to assist in the work of the advisory committee. The advisory committee shall consist of twenty-two members, as follows:

(a) The executive director of the department of public health and environment, or the executive director's designee;

(b) The executive director of the state department, or the executive director's designee;

(c) The executive director of the department of human services, or the state director on aging services within the department of human services;

(d) The Colorado state long-term care ombudsman or the ombudsman's designee;

(e) The executive director of the department of public health and environment shall appoint one member who is a licensed physician, one member who is a registered nurse, and one member who is a licensed psychiatrist, all of whom are familiar with the needs of clients in long-term care settings;

(f) On or before August 1, 2005, the president of the senate shall appoint:

(I) Three members who are representatives of providers of community long-term care services:

(A) One of whom is a representative of home- and community-based services home care providers and one of whom is a certified home health care provider, both of whom shall be appointed from a recommendation of an association representing home care agencies; and

(B) One of whom is a representative of adult day programs;

(II) Two members who are representatives of elderly and disabled long-term care consumers familiar with the needs of clients in long-term care settings;

(III) One member who is a representative of the home- and community-based services provider community with experience in multi-service coordination;

(IV) One member who is a representative of the program of all-inclusive care for the elderly; and

(V) One member who is a social worker with a master's degree in social work.

~~(VI)~~ (g) Of the advisory committee members appointed by the president of the senate pursuant to ~~this~~ paragraph (f) OF THIS SUBSECTION (2), one member shall be from a rural area of Colorado.

~~(g)~~ (h) (I) On or before August 1, 2005, the speaker of the house of representatives shall appoint:

~~(H)~~ (A) One member who is a representative of the affordable housing community;

~~(HH)~~ (B) One member who is a representative of the single entry point system;

~~(HH)~~ (C) One member who is a pharmacist with experience with clients in long-term care settings;

~~(VV)~~ (D) Two members who are nursing home administrators licensed in the state of Colorado, one of whom is a representative of a nonprofit nursing home who shall be appointed from a recommendation of an association representing nonprofit nursing homes and one of whom is a representative of a for-profit nursing home who shall be appointed from a recommendation of an association representing for-profit nursing homes;

~~(V)~~ (E) One member who is an executive director of an assisted living residence in Colorado; and

~~(VI)~~ (F) One member who is a primary care provider from a federally qualified health center and who has significant experience serving persons with disabilities.

~~(VII)~~ (II) Of the advisory committee members appointed by the speaker of the house of representatives pursuant to this paragraph ~~(g)~~ (h), one member shall be

from a rural area of Colorado.

(3) The advisory committee shall identify programs and program modifications that further the intent of the legislative declaration and will:

(a) Create increased flexibility for clients and service delivery along the full continuum of community long-term care including, but not limited to, adult day programs, independent living, alternate care facilities, home care, assisted living residences, congregate housing, subsidized housing, and skilled nursing facilities;

(b) Explore a shift from certified providers and properties to eligible clients and services along the continuum;

(c) Allow consumer choice in the least restrictive environment;

(d) Be research-driven, client-focused, and ensure medicaid funds are utilized in the most cost-effective manner possible;

(e) Provide greater opportunities on the part of clients to direct the care and support they receive;

(f) Provide incentives for skilled nursing facilities to reduce the number of medicaid-certified nursing home beds in pursuit of alternate models of care;

(g) Create an integrated continuum of long-term care benefits and services, including but not limited to an integrated model for reimbursement for community- and facility-based, long-term care settings;

(h) Explore options and models for integrating acute care and long-term care including but not limited to integrated financing and services;

(i) Develop criteria for the state department to use in evaluating and approving coordinated care pilot program proposals pursuant to section ~~26-4-426~~ 25.5-6-109;

(j) Facilitate accountability between the state department and participating providers in order for providers to be efficient, high-quality performers, dedicated to improved client and program outcomes.

(4) The advisory committee shall make recommendations to the state department on or before July 1, 2006, on programs or program modifications that will effectuate the creation of a coordinated continuum of long-term care services and delivery systems, improved structure and quality of provider operations and procedures, and enhanced quality of life for program participants. Prior to the advisory committee submitting the committee's recommendations, the advisory committee shall present the committee's progress to the joint budget committee of the general assembly in December 2005 and April 2006. On or before August 1, 2006, the state department shall forward the advisory committee's recommendations to the governor's office, the joint budget committee of the general assembly, and the health and human services committees of the senate and the house of representatives. The recommendations shall include any legislation or rule changes necessary to implement programs and program modifications that will enhance the current

continuum of community long-term care services and service delivery systems. On or before November 1, 2006, the state department shall report to the joint budget committee of the general assembly the department's progress in implementing the recommendations of the advisory committee.

(5) The state department may accept gifts, grants, or donations to facilitate the work of the advisory committee and to facilitate the state's participation in proposed or emerging service delivery models or research. Any moneys received as gifts, grants, or donations by the state department shall be deposited into the state department's cash fund established in section 25.5-1-109. ~~C.R.S.~~

(6) (a) If the state department receives sufficient gifts, grants, or donations, the state department shall convene the advisory committee and hire the independent facilitator, as required under subsection (2) of this section.

(b) To avoid any conflict of interest, neither the independent facilitator nor the advisory committee members shall be given information by the state department regarding the source of the gifts, grants, and donations.

(7) Members of the advisory committee shall receive no compensation but shall be reimbursed for their actual and necessary expenses. Any actual or necessary expenses incurred by the members of the advisory committee shall be paid for through the gifts, grants, or donations received pursuant to subsection (6) of this section.

(8) For purposes of this section, "community long-term care services" includes, but is not limited to, adult day programs, independent living, alternate care facilities, home care, assisted living residences, congregate housing, subsidized housing, and skilled nursing facilities.

(9) This section is repealed, effective July 1, 2007.

25.5-6-109. [Formerly 26-4-426] Community long-term care - coordinated care pilot program - federal authorization - rules - repeal. (1) Notwithstanding section ~~26-4-113 (1.5) (b)~~ 25.5-5-402 (2) (b), the state department shall accept and may approve proposals for a three-year coordinated care pilot program for community long-term care services, referred to in this section as the "pilot program". The pilot program shall include at least two rural communities, three urban communities, and specific populations designated by the state department.

(2) Organizations may develop proposals for the pilot program and submit the proposals to the state department for approval. The state department shall oversee any approved pilot program. The approved pilot program shall include but need not be limited to the following components:

- (a) Voluntary recipient enrollment and participation in the pilot program;
- (b) Voluntary provider participation in the coordinated care pilot;
- (c) Provider network adequacy;

(d) Contracting with organizations capable of coordinating care for medicaid patients using a model that demonstrates cost savings including but not limited to the coordination of services and maintenance of an adequate network of providers for covered services;

(e) An evaluation of the pilot program's outcomes, including but not limited to program costs, the benefits to the recipient and the state, and any net fiscal savings.

(3) Notwithstanding any provision of this article AND ARTICLES 4 AND 5 OF THIS TITLE to the contrary, the state department shall have flexibility in determining the reimbursement for acute care providers, long-term care community providers, and class I nursing facilities when it is necessary to serve a pilot program participant in a more medically appropriate and cost-effective setting.

(4) The state board shall promulgate any rules necessary for the implementation of this section.

(5) It is the general assembly's intent that coordinating the care of medicaid patients under the pilot program will be cost-effective for the state's medicaid program. The state department, therefore, is authorized to use savings in the medical services premiums appropriations to fund the pilot program authorized in this section.

(6) The state department shall seek any necessary federal authorization for the implementation of this section and contract with an outside entity for such purposes, contingent on the receipt of sufficient gifts, grants, or donations.

(7) This section is repealed, effective July 1, 2010.

25.5-6-110. [Formerly 26-4-506.7] Private-public partnership education and information program concerning long-term care insurance authorized.

(1) The general assembly hereby declares that:

(a) A large number of Coloradans are in need of long-term health care;

(b) The cost of long-term care, especially nursing home care, is significant;

(c) Many persons in need of long-term care are ineligible for state medical assistance due to countable resources. When faced with the need for long-term care, such persons expend such resources to pay for nursing home care.

(d) A person's resources may cover only a relatively short period of care, often resulting in rendering such person impoverished, and after which time the person must rely on state medical assistance;

(e) Expenditures for long-term care represent a significant portion of the state's medical assistance budget;

(f) Unless Colorado implements new methods for financing long-term care, which methods include participation by the private sector, the cost to the state for long-term care will increase astronomically; and

(g) It is therefore appropriate to enact legislation that allows the state department, upon a determination by the executive director of the state department that it is feasible, to design and implement a private-public partnership for financing long-term care in this state.

(2) The state department shall cooperate with the division of insurance in the department of regulatory agencies in a private-public partnership for financing long-term care in this state through the availability of long-term care insurance policies that result in a reduction of total dependency on the medical assistance program to finance such care. It is the general assembly's intent that such partnership shall be designed to encourage individuals to purchase long-term care insurance, which, with respect to middle to higher income individuals, will have the result of eliminating or delaying the individual's need for medical assistance.

(3) Under the partnership described in subsection (2) of this section, the division of insurance shall implement statutory changes to article 19 of title 10, C.R.S., concerning long-term care policies that the general assembly hereby declares are necessary to accomplish the purpose of the partnership described in this section. In addition, the state department is encouraged to implement a public education-awareness program based on recommendations from an advisory committee that the executive director of the state department is hereby authorized to establish.

(4) The state department is authorized to seek and accept funds, grants, or donations from any private entity for implementing the public education-awareness program. In addition, if necessary, the state department may assess a fee in connection with conducting any public education-awareness training program or seminar. Any such fee collected shall be transmitted to the state treasurer, who shall credit the same to the long-term care insurance fund, which fund is hereby created. The moneys in the fund shall be subject to annual appropriation by the general assembly for the sole purpose of public education-awareness training programs and seminars.

(5) In addition to administering the public education-awareness program under the partnership, the state department shall seek a federal waiver from the requirement of section 13612 of the federal "Omnibus Budget Reconciliation Act of 1993" (OBRA), Public Law 103-66, that prevents the state department from granting medical assistance applicants a full or partial resource exemption in determining eligibility for medical assistance and an exemption from estate recovery requirements.

(6) The state department, if funds are available, shall contract with a public or private entity to conduct an evaluation of the public education-awareness program on or before December 1, 2000.

(7) With respect to a policyholder who has allowed his or her private long-term care insurance policy to lapse, if the person is found to be eligible for the medical assistance program, the state department is authorized to pay the premium for a reinstated policy pursuant to section 10-19-107 (2), C.R.S., if the state department finds that to do so is feasible and cost-efficient.

PART 2
NURSING FACILITIES

25.5-6-201. [Formerly 26-4-502] Special definitions relating to nursing facility reimbursement. As used in this part 5, and for purposes of section ~~26-4-410~~ PART 2, unless the context otherwise requires:

(1) "Actual cost" means the allowable audited cost of providing services.

~~(1.5)~~ (2) "Administration, property, and room and board costs" means costs in the following categories:

(a) Advertising, recruitment, and public relations, to the extent that such costs are necessary, reasonable, and patient-related;

(b) Travel and training of facility staff, unless the travel includes residents of the facility or the training is for the facility staff described in paragraph (a) of subsection ~~(2)~~ (3) of this section;

(c) All other costs that are not health care services, food costs, or capital-related assets.

~~(2)~~ (3) "Health care services" means the following categories of patient support services, including, where applicable, salaries, payroll taxes, workers' compensation payments, training, and other employee benefits:

(a) Registered nurses, licensed practical nurses, aides, medical records librarians, social workers, and activity personnel;

(b) Nonprescription drugs ordered by a physician;

(c) Consultant fees for nursing, medical records, patient activities, social workers, pharmacies, physicians, and therapies;

(d) Repair expenses for health care equipment, purchases of health care equipment, health care equipment rentals, and supplies for nursing, medical records, social workers, activity personnel, and recreational therapy;

(e) Medical director fees;

(f) Therapies and services, including:

(I) Utilization review;

(II) Dental care, when required by federal law;

(III) Audiology;

(IV) Psychology;

(V) Physical therapy;

(VI) Recreational therapy; and

(VII) Occupational therapy;

(g) Other patient support services determined and defined by the ~~medical services~~ STATE board pursuant to rule; ~~and regulation~~;

(h) Purchase or rental of motor vehicles and related expenses for operating or maintaining the vehicles to the extent that they are used to transport residents to activities or medical appointments;

(i) Malpractice insurance;

(j) Depreciation and interest for major health care equipment, such as equipment purchased for the sole purpose of providing care to facility residents; and

(k) Photocopying related to health care purposes such as medical records of patients.

~~(3)~~ (4) "Reasonable cost of services" means the maximum allowable reimbursement as determined under section ~~26-4-410 (4) (a)~~ 25.5-6-204 (4) (a).

25.5-6-202. [Formerly 26-4-502.5] Definitions relating to reimbursement of case-mix adjusted nursing costs. As used in this ~~part 5, and for the purposes of section 26-4-410~~ PART 2, unless the context otherwise requires:

(1) "Case-mix adjusted nursing costs" means those costs comprising the compensation, salaries, bonuses, worker's compensation, employer-contributed taxes, and other employment benefits attributable to a nursing facility provider's direct care nursing staff whether employed directly or as contract employees, including but not limited to registered nurses, licensed practical nurses, and nurse's aides.

(2) "Case-mix index" means a numeric score assigned to each nursing facility resident based upon the resident's physical and mental condition that reflects the amount of relative resources required to provide care to that resident.

(3) "Case-mix reimbursement component" means that portion of the nursing facility provider's medicaid rate comprised of case-mix adjusted nursing costs.

(4) "Facility population distribution" means the number of Colorado nursing facility residents that are classified into each resource utilization group as of a specific point in time.

(5) "Index maximization" means classifying a resident who could be assigned to more than one category to the category with the highest case-mix index.

(6) "Minimum data set" means a set of screening, clinical and functional status elements that are used in the assessment of a nursing facility provider's residents under the federal medicare and medicaid programs.

(7) "Normalization ratio" means the statewide average case-mix index divided by the facility's cost report period case-mix index.

(8) "Normalized" means multiplying the nursing facility provider's per diem case-mix adjusted nursing cost by its case-mix index normalization ratio for the purpose of making the per diem cost comparable among facilities based upon a common case-mix in order to determine the maximum allowable reimbursement limitation.

(9) "Nursing salary ratios" means the relative difference in hourly wages of registered nurses, licensed practical nurses, and nurse's aides.

(10) "Nursing weights" means numeric scores assigned to each category of the resource utilization groups that measure the relative amount of resources required to provide nursing care to a nursing facility provider's residents.

(11) "Resource utilization groups" means the system for grouping a nursing facility's residents according to their clinical and functional status as identified from data supplied by the facility's minimum data set as published by ~~the health care financing administration of the United States department of health and human services.~~

25.5-6-203. [Formerly 26-4-503] Definitions relating to reimbursement of rental allowance for capital-related assets. As used in this ~~part 5~~ PART 2, unless the context otherwise requires:

(1) "Acquisition cost" means the actual allowable cost to the owners of a capital-related asset or any improvement thereto as determined in accordance with generally accepted accounting principles.

(2) "Appraised value" means the determination by a qualified appraiser who is a member of an institute of real estate appraisers or its equivalent of the depreciated cost of replacement of a capital-related asset to its current owner. The depreciated replacement appraisal shall be based on the "Boechk Commercial Underwriter's Valuation System for Nursing Homes", December 1985 edition. The depreciated cost of replacement appraisal shall be redetermined every four years by new appraisals of the nursing facilities. Such new appraisals shall be based upon rules ~~and regulations promulgated by the medical services STATE board in the STATE department. of health care policy and financing.~~

(3) (a) "Base value" means:

~~(f) (A) For the fiscal year 1985-86, the acquisition cost of a capital-related asset together with any increase or decrease each year since the date of acquisition as reflected in the index.~~

~~(B) In determining the base value for the fiscal year 1985-86 of a capital-related asset acquired prior to July 1, 1981, the date of acquisition shall be deemed to be July 1, 1981.~~

~~(H) (I) For the fiscal year 1986-87 and every fourth year thereafter, the appraised~~

value of a capital-related asset;

~~(HH)~~ (II) For each year in which an appraisal is not done pursuant to subparagraph ~~(HH)~~ (I) of this paragraph (a), the most recent appraisal together with fifty percent of any increase or decrease each year since the last appraisal as reflected in the index.

(b) For the fiscal year 1985-86, the base value shall not exceed twenty-five thousand dollars per licensed bed at any participating facility, and, for each succeeding fiscal year, the base value shall not exceed the previous year's limitation adjusted by any increase or decrease in the index.

(c) An improvement to a capital-related asset, which is an addition to that asset, as defined through rules adopted by the state ~~department~~ BOARD, shall increase the base value by the acquisition cost of the improvement.

(4) "Capital-related asset" means the land, buildings, and fixed equipment of a participating facility.

(5) "Fair rental allowance" means the product obtained by multiplying the base value of a capital-related asset by the rental rate.

(6) "Improvement" means the addition to a capital-related asset of additional land, buildings, or fixed equipment.

(7) "Index" means the R. S. Means construction systems cost index or an equivalent index that is based upon a survey of prices of common building materials and wage rates for nursing home construction.

(8) "Rental rate" means the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent; except that the rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.

25.5-6-204. [Formerly 26-4-410] Providers - reimbursement - fees - nursing facility - nursing facility patient program improvement fund - intermediate care facility for the mentally retarded - reimbursement - maximum allowable - nonmonetary incentive program - legislative declaration. (1) (a) ~~(H)~~ For the purpose of making payments to private, nonprofit, or proprietary nursing facility providers and intermediate care facilities for the mentally retarded, the state department shall establish a price schedule to be readjusted every twelve months, that shall reimburse, subject to available appropriations, each such provider, as nearly as possible, for its actual or reasonable cost of services rendered, whichever is less, its case-mix adjusted nursing costs as defined in section ~~26-4-502.5 (1)~~ 25.5-6-202 (1), and a fair rental allowance for capital-related assets as defined in section ~~26-4-503 (4)~~ 25.5-6-203 (4). The state ~~department~~ BOARD shall adopt rules, including uniform accounting or reporting procedures, in order to determine such actual or reasonable cost of services and case-mix adjusted nursing costs and the reimbursement therefor. The provisions of this ~~subparagraph (I)~~ PARAGRAPH (a) shall not apply to state-operated intermediate care facilities for the mentally retarded.

~~(H)~~ (b) State-operated intermediate care facilities for the mentally retarded shall be reimbursed based on the actual costs of administration, property, including capital-related assets, and room and board, and the actual costs of providing health care services, and such costs shall be projected by such facilities and submitted to the state department by July 1 of each year for the ensuing twelve-month period. Reimbursement to state-operated intermediate care facilities for the mentally retarded shall be adjusted retrospectively at the close of each twelve-month period. The state ~~department~~ BOARD shall adopt rules ~~and regulations~~ to be effective by June 30, 1988, implementing the provisions of this ~~subparagraph (H)~~ PARAGRAPH (b). In the implementation of such rules, the state department shall ~~insure~~ ENSURE, by the establishment of classes of facilities, that the reimbursement to private, nonprofit, or proprietary state-operated intermediate care facilities for the mentally retarded or developmentally disabled, as defined in section 27-10.5-102 (11), C.R.S., is not adversely impacted.

~~(b) and (c) (Deleted by amendment, L. 2000, p. 1996, § 1, effective June 2, 2000.)~~

~~(d)~~ (c) (I) Beginning in fiscal year 2003-04, and for each fiscal year thereafter, the department of human services is authorized to charge both privately owned intermediate care facilities for the mentally retarded and state-operated intermediate care facilities for the mentally retarded a service fee for the purposes of maintaining the quality and continuity of services provided by intermediate care facilities for the mentally retarded. The service fee charged by the department of human services pursuant to this paragraph ~~(d)~~ (c) shall not exceed five percent of the costs incurred by each intermediate care facility for the fiscal year in which the service fee is charged. The state board of human services shall adopt rules consistent with federal law in order to implement the provisions of this paragraph ~~(d)~~ (c).

(II) The moneys collected in each fiscal year pursuant to subparagraph (I) of this paragraph ~~(d)~~ (c) shall be transmitted by the department of human services to the state treasurer, who shall credit same to the service fee fund, which fund is hereby created and referred to in this paragraph ~~(d)~~ (c) as the "fund". The moneys in the fund shall be subject to annual appropriation by the general assembly to the state department to be used toward the state match for the federal financial participation to reimburse intermediate care facilities for the mentally retarded pursuant to this section. Any unexpended and unencumbered moneys remaining in the fund at the end of any fiscal year shall remain in the fund and not be credited or transferred to the general fund or any other fund.

(2) ~~(a) Repeated:~~

~~(b)~~ (a) In addition to such actual or reasonable costs and the reimbursement therefor, the state department shall, subject to available appropriations, include an allowance, equal to the change in the national bureau of labor statistics consumer price index from the preceding year, which is to compensate for fluctuating costs. This amount shall be determined every twelve months when the statewide average cost is determined by adjusting for inflation. The nursing facility provider's allowable cost shall be multiplied by the change in the consumer price index measured from the midpoint of the provider's cost report period to the midpoint of the provider's rate period. This allowance is applied to all costs, including case-mix

adjusted nursing costs as that term is defined in section ~~26-4-502.5 (1)~~ 25.5-6-202 (1), less interest, up to the reasonable cost established and will be allowed to proprietary, nonprofit, and tax-supported homes; except that such allowance shall not be applied to the costs of state-operated intermediate facilities for the mentally retarded.

~~(c)~~ (b) (I) The ~~medical services~~ STATE board shall adopt rules ~~and regulations~~ to:

~~(f) Repealed.~~

~~(H)~~ (A) Determine and pay to privately owned intermediate care facilities for the mentally retarded a reasonable share of the amount by which the reasonable costs of the categories of administration, property, and room and board, excluding food costs, exceed the actual cost in these categories only. Such reasonable share shall be defined as twenty-five percent of such amount in such categories for each facility, not to exceed twelve percent of the reasonable cost.

~~(B) (Deleted by amendment, L. 2003, p. 408, § 1, effective March 5, 2003.)~~

~~(B.1)~~ (B) For fiscal year 2003-04, and for each fiscal year thereafter, determine and pay to nursing facility providers a reasonable share of the amount by which the reasonable costs of the categories of administration, property, and room and board, excluding food costs, exceed the actual cost in these categories only of each facility provider. Such reasonable share shall be defined as twelve and one-half percent of such amount in such categories for each facility, not to exceed twelve percent of the reasonable cost. As used in this sub-subparagraph ~~(B.1)~~ (B), "nursing facility provider" means a facility provider that meets the state nursing home licensing standards in section 25-1.5-103 (1) (a), C.R.S., is maintained primarily for the care and treatment of inpatients under the direction of a physician, and meets the requirements in 42 U.S.C. sec. 1396d for certification as a qualified provider of nursing facility services.

~~(C)~~ (II) This ~~subparagraph (H)~~ PARAGRAPH (b) shall take effect January 1, 1995.

~~(c.5) (Deleted by amendment, L. 2002, p. 1930, § 1, effective July 1, 2002.)~~

~~(c.6)~~ (c) The department may research and develop a nonmonetary incentive program for nursing facility providers. Such program shall recognize those nursing facility providers who achieve the highest quality-of-care standards within their facilities.

~~(c.7)~~ (d) (I) Beginning July 1, 2003, subject to available appropriations, there is hereby established a resident-centered quality improvement program, which shall be known as ResQUIP, for the purpose of encouraging improvement in the quality of life in nursing facilities by resident participation in life-enriching activities that promote enhanced communication, better understanding of resident needs and self-determination, and building positive relationships and a sense of community in a nonthreatening environment that provides an encouraging and accepting atmosphere.

(II) The state department may issue incentive grants under the program, subject

to available appropriations, to nursing facility providers that meet the criteria established by the state ~~department~~ BOARD by rule. A nursing facility provider may also apply for an incentive payment.

(III) Applicants for program incentive grants shall clearly define a resident-centered program proposal pursuant to rules established by the state department. Such application shall include a request for a specific grant amount. Proposals and requests for a specific grant amount may include direct and indirect costs including enhanced education and training for staff, human resource expenditures, and other activities that may encourage improvement in the quality of life of residents in nursing facilities.

(IV) Rules issued by the state ~~department~~ BOARD regarding the incentive grant program shall include requirements in applications by providers for participation by residents or family members.

(V) The state department and the ResQUIP team of each nursing care facility that receives an incentive grant shall conduct an evaluation of the proposal to demonstrate program and financial accountability, on at least an annual basis, to ensure that the grants are spent only on the implementation of the proposal. The composition of each ResQUIP team shall be established by rule of the state ~~department~~ BOARD. Any payments that are not spent on the proposal shall be returned to the state department.

(VI) Beginning July 1, 2004, and each July 1 thereafter, the state department shall report annually to the members of the ~~health, environment, welfare, and institutions~~ HEALTH AND HUMAN SERVICES committees of the house of representatives and the senate, OR ANY SUCCESSOR COMMITTEES, on consumer satisfaction surveys and other facility information. For each nursing facility, this report shall contain information on the survey results, the number of complaints, and the number of occurrences that are reported to the department of public health and environment pursuant to section 25-1-124, C.R.S.

~~(d)~~ (e) There is hereby established within the STATE department a nursing facility patient program improvement fund. The state department shall pay out of such fund, subject to rules ~~and regulations~~ adopted by the ~~medical services~~ STATE board and subject to appropriations made for that purpose by the general assembly, moneys to any qualified nursing facility submitting a proposal which would provide medicaid services to a more difficult patient case mix or which would improve quality of care and quality of life within the qualifying facility.

(3) For the purpose of making payments for providers' services, the rules ~~and regulations~~ established by the state ~~department~~ BOARD shall provide that, in the determination of reasonable compensation, the criteria provided under Title XVIII of the social security act shall be taken into consideration. The state has authority to implement prospective rate reimbursement for providers where appropriate; except that the state department is authorized to pass payments through to nursing facility providers in advance of providers' implementation of the automated minimum data-set system, in accordance with the federal "Omnibus Budget Reconciliation Act of 1987". The state department shall not arbitrarily discriminate between physicians and optometrists who provide similar services, goods, and

prosthetic devices in the field of vision care within the scope of their respective practices, as defined by state law.

(4) (a) For the purposes of this section, "reasonable costs" means the maximum allowable reimbursement based on the following categories of costs:

(I) Actual health care services and food costs; and

(II) Actual administration, property, and room and board costs, excluding capital-related assets and excluding food costs.

~~(a.5)~~ (b) Case-mix adjusted nursing costs shall be subject to the maximum allowable reimbursement limitation on health care costs as set forth in sub-subparagraph (A) of subparagraph (II) of paragraph ~~(b)~~ (c) of this subsection (4). In determining the maximum allowable reimbursement limitation, case-mix adjusted nursing costs shall be normalized, as defined in section ~~26-4-502.5~~ ~~(8)~~ 25.5-6-202 (8), for each nursing facility provider based upon the average of the provider's quarterly case-mix indices for residents during the provider's most recently reported cost reporting period.

~~(b)~~ (c) Effective July 1, 1995, the maximum allowable reimbursement shall not exceed the following amounts in the following categories:

(I) **Administrative costs:** (A) Class I facilities: One hundred twenty percent of the weighted average actual costs of all class I facilities;

(B) Class II facilities: One hundred twenty percent of the weighted average actual costs of all class II facilities;

(C) Class IV facilities: One hundred twenty percent of the weighted average actual costs of all class IV facilities;

(II) **Health care - food and case-mix adjusted nursing costs:** (A) Class I facilities: One hundred twenty-five percent of the weighted average actual costs of all class I facilities adjusted for facility case-mix weight;

(B) Class II facilities: One hundred twenty-five percent of the weighted average actual costs of all class II facilities;

(C) Privately owned class IV facilities: One hundred twenty-five percent of the weighted average actual costs of all class IV facilities.

~~(b.5)~~ (d) For the purpose of calculating both the individual nursing facility provider's rates and the maximum allowable reimbursement rates identified in subparagraphs (I) and (II) of paragraph ~~(b)~~ (c) of this subsection (4), only administrative costs as defined in section ~~26-4-502~~ ~~(1.5)~~ 25.5-6-201 (2) shall be imputed to the eighty-fifth percentile for urban facilities with occupancy rates below eighty-five percent.

~~(c)~~ (e) Food costs shall not include the costs of real or personal property, staff, preparation, or other items related to the food program. The dollar amount per

patient day shall be established every twelve months in accordance with rules established by the ~~medical services~~ STATE board.

~~(d)~~ (f) (I) The general assembly finds that the historical growth in nursing facility rates has significantly exceeded the rate of inflation. These increases have been caused in part by the inclusion of medicare costs in medicaid cost reports. The state of Colorado has an interest in limiting these exceptional increases in medicaid nursing facility rates by imposing growth ceilings on nursing facility rates, instituting a case-mix reimbursement system, removing medicare part B direct costs from the medicaid nursing facility rates, and imposing a ceiling on the medicare part A ancillary costs that are included in calculating medicaid nursing facility rates.

(II) Notwithstanding any other provision in this article AND ARTICLES 4 AND 5 OF THIS TITLE, the following limitations shall apply to rates for reimbursement of nursing facilities:

(A) For all rates effective on or after July 1, 1997, for each class I and class V facility, any increase in administrative costs shall not exceed six percent per year; and

(B) For all rates effective on or after July 1, 1997, for each class I and class V facility, only such costs as are reasonable, necessary, and patient-related may be reported for reimbursement purposes. Nursing facilities may include whatever level of medicare part A ancillary costs was included and allowed in the facility's latest medicaid cost report filed prior to July 1, 1997. Any subsequent increase in this amount shall be limited to either the increase in the facility's allowable medicare part A ancillary costs or the percentage increase in the cost of medical care reported in the United States department of labor bureau of labor statistics consumer price index for the same time period, whichever is lower. Part B direct costs for medicare shall be excluded from the allowable reimbursement for facilities.

(III) The specific methodology for calculating the limitations and cost reporting requirements described in this paragraph ~~(d)~~ (f) shall be established by rules promulgated by the state ~~department~~ BOARD.

~~(e)~~ (g) The state department is authorized to utilize a case-mix system for reimbursing some or all of Colorado's class I and class V medicaid nursing facilities. A case-mix reimbursement system reimburses each facility according to the resource consumption in treating its case mix of medicaid residents, which may include such factors as the age, health status, resource utilization, and diagnoses of the facility's medicaid residents.

~~(f)~~ (h) Effective July 1, 2000, a case-mix reimbursement component, as defined in section ~~26-4-502.5 (3)~~ 25.5-6-202 (3), for nursing costs shall be paid to class I and class V nursing facility providers and implemented as follows:

(I) The state department shall determine each resident's clinical and functional status as identified and reported by each nursing facility provider using the federal medicare and medicaid program minimum data set assessment.

(II) For the purpose of determining each provider's case-mix index, the STATE

department shall use the resource utilization groups classification system, nursing weights only. In classifying residents, an index maximization approach shall be used. Nursing weights shall be calculated based upon standard nursing time studies and weighted by Colorado specific nursing salary ratios and facility population distribution as defined in section ~~26-4-502.5 (9)~~ and ~~(4)~~ 25.5-6-202 (9) AND (4).

(III) An average case-mix index shall be determined for each nursing facility provider's medicaid recipients on a quarterly basis.

(IV) The state board shall promulgate such rules as are necessary to implement the case-mix reimbursement system pursuant to this paragraph ~~(f)~~ (h).

(5) (a) (I) Interested members of the joint budget committee of the general assembly, the state department, the state ombudsman and interested long-term care ombudsmen, and nursing facility providers shall develop a methodology for determining when and under what circumstances a limitation on the increase in health care services costs for class I and class V facilities shall be implemented. The methodology may take into consideration factors including but not limited to nursing facility caseload, the implementation of refinancing mechanisms, federal mandates, inflation, and other economic factors.

(II) The members of the group specified in subparagraph (I) of this paragraph (a) shall report to the joint budget committee of the general assembly by November 15, 2002, with recommendations for a methodology for determining when and under what circumstances there shall be implementation of a limitation on the increase in health care services costs for class I and class V facilities. The general assembly shall enact legislation by July 1, 2003, implementing a methodology for determining when and under what circumstances a limitation on the increase in health care services costs shall be implemented, which legislation shall include a repeal of paragraph (b) of this subsection (5).

(b) In the event the general assembly fails to enact legislation by July 1, 2003, specifying when and under what conditions a limitation on the increase in nursing facility health care costs shall be imposed, then for rates effective on and after July 1, 2005, in addition to the limitations specified in subparagraph (II) of paragraph ~~(d)~~ (f) of subsection (4) of this section, for each class I and class V facility, any increase in health care services costs shall not exceed eight percent per year. The calculation of the eight percent per year limitation for rates effective on or after July 1, 2005, shall be based on the facility's cost reports, as specified by rule of the ~~medical services~~ STATE board, in the preceding year.

25.5-6-205. [Formerly 26-4-505] Collection of penalties assessed against nursing facilities - creation of cash fund. (1) (a) The state department shall assess, enforce, and collect any civil penalties ~~which~~ THAT are recommended by the department of public health and environment pursuant to the authority granted under section 25-1-107.5, C.R.S.

(b) Prior to the denial of medicaid payments or the assessment of a civil money penalty against a nursing facility, the nursing facility shall be offered by the state department an opportunity for a hearing in accordance with the provisions of section 24-4-105, C.R.S. Enforcement and collection of the denial of medicaid payments

or civil money penalty shall occur following the decision reached at such hearing.

(2) In conjunction with the authority granted under subsection (1) of this section, the state ~~department~~ BOARD shall promulgate rules ~~and regulations which~~ THAT:

(a) Provide any nursing facility assessed a civil penalty the opportunity to appeal such assessment;

(b) Govern the procedures for such appeals, including the right of a nursing facility to thirty days' notice prior to the collection of any civil money penalty; and

(c) Are otherwise necessary to implement this section.

(3) (a) Any civil penalties collected by the state department pursuant to this section shall be transmitted to the state treasurer, who shall credit the same to the nursing home penalty cash fund, which fund is hereby created.

(b) (I) The moneys in the fund are subject to annual appropriation by the general assembly to the STATE department ~~of health care policy and financing~~ for the purposes set forth in ~~sections~~ SECTION 25-1-107.5, C.R.S. ~~and 26-4-420, C.R.S.~~

(II) Such moneys shall be used in the manner prescribed in section 25-1-107.5, C.R.S., and the rules ~~and regulations~~ promulgated thereunder.

~~(III) to (V) Repealed.~~

(c) All interest derived from the deposit and investment of moneys in the fund shall be credited to the fund.

(d) At the end of any fiscal year, all unexpended and unencumbered moneys remaining in the fund shall remain therein and shall not be credited or transferred to the general fund or any other fund.

25.5-6-206. [Formerly 26-4-504] Personal needs benefits - amount - patient personal needs trust fund required - funeral and burial expenses - penalty for illegal retention and use. (1) The state department, pursuant to its rules, ~~and regulations~~, shall have the authority to include in medical care benefits provided under this article AND ARTICLES 4 AND 5 OF THIS TITLE reasonable amounts for the personal needs of any recipient receiving nursing facility services or intermediate care facilities for the mentally retarded, if the recipient is not otherwise eligible for such amounts from other categories of public assistance, but such amounts for personal needs shall not be less than the minimum amount provided for in subsection (2) of this section. Payments for funeral and burial expenses upon the death of a recipient may be provided under rules ~~and regulations~~ of the state department in the same manner as provided to recipients of public assistance as defined by section 26-2-103 (8), C.R.S.

(2) (a) The basic minimum amount payable pursuant to subsection (1) of this section for personal needs to any recipient admitted to a nursing facility or intermediate care facility for the mentally retarded shall be fifty dollars monthly.

(b) ~~(F)~~ On and after October 1, 1992, the basic minimum amount payable pursuant to subsection (1) of this section for personal needs shall be ninety dollars for the following persons:

~~(A)~~ (I) A medical assistance recipient who receives a non-service connected disability pension from the United States veterans administration, has no spouse or dependent child, and is admitted to or is residing in a nursing facility; and

~~(B)~~ (II) A medical assistance recipient who is a surviving spouse of a person who received a non-service connected disability pension from the United States veterans administration, has no dependent child, and is admitted to or is residing in a nursing facility.

~~(H) Repealed.~~

(3) (a) All personal needs funds shall be held in trust by the nursing facility or intermediate care facility for the mentally retarded, or its designated trustee, separate and apart from any other funds of the facility. The facility shall deposit any personal needs funds of a resident in an amount of fifty or more dollars in an interest-bearing checking account or accounts or savings account or any combination thereof established to protect and separate the personal needs funds of the patients. Any interest earned on a resident's personal needs funds shall be credited to such account or accounts. In the event residents' personal needs funds are maintained in a pooled account, separate accountings shall be made for each resident's share of the pooled account. Any personal needs funds of a resident in an amount less than fifty dollars shall be maintained in a non-interest-bearing account, an interest-bearing account, or a petty cash fund.

(b) At all times, the principal and all income derived from said principal in the patient personal needs trust fund shall remain the property of the participating patients, and the facility or its designated trustee is bound by all of the duties imposed by law upon fiduciaries in the handling of such fund. Those duties include but are not limited to providing notice to a resident when the resident's personal needs account accumulates two hundred dollars less than the federal supplemental security income resource limit for one person.

(c) The facility or its designated trustee shall post a surety bond in an amount to assure the security of all personal needs funds deposited in the patient personal needs trust fund or shall otherwise demonstrate to the satisfaction of the state department that the security of residents' personal needs funds is assured.

(d) Within sixty days after a resident's death, the facility shall transfer the resident's personal needs funds and a final accounting of the funds to the person responsible for settling the resident's estate or, if there is none, to the resident's heirs in accordance with the provisions of title 15, C.R.S. Within fifteen days after receiving the funds, the executor, administrator, or other appropriate representative of the resident's estate shall provide written notice to the state department regarding the receipt of the funds. Upon receipt of the notice, the state department may bring an action to recover the funds pursuant to the provisions of this article AND ARTICLES 4 AND 5 OF THIS TITLE.

(4) The state department shall establish rules ~~and regulations~~ concerning the establishment of a patient personal needs trust fund and procedures for the maintenance of a system of accounting for expenditures of each patient's personal needs funds. The facility shall use an accounting system that assures a complete and separate accounting of residents' personal needs funds based on generally accepted accounting principles and that precludes the commingling of a resident's personal needs funds with the facility's funds or the funds of any other person other than the personal needs funds of another resident. These rules ~~and regulations~~ shall provide that the nursing facility or intermediate care facility for the mentally retarded shall maintain complete records of all receipts and expenditures involving the patient personal needs trust fund, that all expenditures shall be approved by the patient, legal custodian, guardian, or conservator prior to an expenditure, and that each patient or such patient's legal custodian, guardian, or conservator shall be given at least a quarterly accounting of the receipts and expenditures of such funds. In addition, the rules shall require that the person who maintains the patient personal needs trust fund for the facility and who is responsible for the deposit of moneys into such trust fund shall deposit any personal needs funds received from a patient or from the state department no later than sixty days after the receipt of such moneys.

(5) All patient personal needs trust funds shall be subject to audit by the state department. A record of a patient's personal needs trust fund shall be kept by the facility for a period of three years from the date of the patient's discharge from the facility or until such records have been audited by the state department, whichever occurs later.

(6) Any overpayment of personal needs funds to a nursing facility or an intermediate care facility for the mentally retarded by the state department due to the omission, error, fraud, or defalcation of the nursing facility or intermediate care facility for the mentally retarded or any shortage in an audited patient personal needs trust fund shall be recoverable by the state on behalf of the recipient in the same manner and following the same procedures as specified in section ~~26-4-403~~ ~~(2)~~ 25.5-4-301 (2) for an overpayment to a provider.

(7) Nothing in this section shall prevent a nursing facility or intermediate care facility for the mentally retarded patient from excluding himself OR HERSELF from participation in the patient personal needs trust fund.

(8) (a) It is unlawful for any person to knowingly fail to deposit personal needs funds received from a patient or from the state department for a patient's personal needs into the patients' personal needs trust fund within sixty days after the receipt of such moneys or to knowingly apply, spend, commit, pledge, or otherwise use a patient personal needs trust fund, or any other moneys paid by a patient or the state department for patient personal needs, for any purpose other than the personal needs of the patient to purchase necessary clothing, incidentals, or other items of personal needs ~~which~~ THAT are not reimbursed by any federal or state program. Deposit or use of personal needs funds, including the use of a petty cash fund for personal needs purposes, is not a violation of this section if such deposit or use is in substantial compliance with applicable ~~regulations~~ RULES of the state department, nor shall sums later ordered repaid to the patients' personal needs trust fund as a result of an audit adjustment or a dispute related to a proration of patient payment

be determined to constitute a violation of this section.

(b) Any person who knowingly violates any of the provisions of this subsection (8) by failing to deposit personal needs funds within sixty days ~~of~~ AFTER the receipt of such moneys commits the crime of unlawful retention of patient personal needs funds. Any person who violates any of the provisions of this subsection (8) by applying, spending, committing, pledging, or otherwise using a patient personal needs trust fund for any purpose other than the purposes permitted by this subsection (8) commits the crime of unlawful use of a patient personal needs trust fund.

(c) Unlawful retention of patient personal needs funds is a class 3 misdemeanor. When a person commits unlawful retention of patient personal needs funds twice or more within a period of six months without having been placed in jeopardy for the prior offense or offenses, unlawful retention of patient personal needs funds is a class 1 misdemeanor.

(d) Unlawful use of a patient personal needs trust fund is:

(I) A class 3 misdemeanor, if the amount involved is less than one hundred dollars;

(II) A class 2 misdemeanor, if the amount involved is one hundred dollars or more but less than five hundred dollars;

(III) A class 4 felony, if the amount involved is five hundred dollars or more but less than fifteen thousand dollars;

(IV) A class 3 felony, if the amount involved is fifteen thousand dollars or more.

(e) Any person who is convicted of violating this subsection (8) may not own or operate a nursing facility that receives medical assistance pursuant to this article OR ARTICLE 4 OR 5 OF THIS TITLE. For the purposes of this paragraph (e), "convicted" means the entry of a plea of guilty, including a plea of guilty entered pursuant to a deferred sentence under section 18-1.3-102, C.R.S., the entry of a plea of no contest accepted by the court, or the entry of a verdict of guilty by a judge or jury.

PART 3 HOME- AND COMMUNITY-BASED SERVICES FOR THE ELDERLY, BLIND, AND DISABLED

25.5-6-301. [Formerly 26-4-601] Short title - citation. ~~This subpart 1 shall be comprised of sections 26-4-601 to 26-4-612 and may be cited as subpart 1. The title of this subpart 1~~ THIS PART 3 shall be known and may be cited as the "Home- and Community-based Services for the Elderly, Blind, and Disabled Act".

25.5-6-302. [Formerly 26-4-602] Legislative declaration. The general assembly hereby finds and declares that it is the purpose of this ~~subpart 1~~ PART 3 to provide, under a federal waiver of statutory requirements, for an array of home- and community-based services to eligible elderly, blind, and disabled individuals as an alternative to nursing facility placement.

25.5-6-303. [Formerly 26-4-603] Definitions. As used in this ~~subpart 1 and subpart 3 of this part 6~~ PART 3 AND PART 5 OF THIS ARTICLE, unless the context otherwise requires:

(1) "Adult day care facility" means a facility which meets all applicable state and federal requirements and is certified by the state to provide adult day care services to eligible persons.

(2) "Adult day care services" means health and social services provided on a less than twenty-four-hour basis to eligible persons in state-certified adult day care facilities.

(3) "Alternative care facility" means a residential facility which provides alternative care services and protective oversight to eligible persons, which meets applicable state and federal requirements, and which is state-certified.

(4) "Alternative care services" means a package of personal care and homemaker services provided in a state-certified alternative care facility.

(5) (a) ~~(f) Repealed.~~

~~(ff) Case management~~ "CASE MANAGEMENT AGENCY" MEANS agencies providing services on and before July 1, 1995, for home- and community-based programs for the elderly, blind, and disabled and for persons living with AIDS shall be terminated July 1, 1995, and case management functions shall thereafter be performed in accordance with ~~sections 26-4-521 to 26-4-525 and this part 6~~ THIS ARTICLE.

(b) "Case management agency", for counties participating in the single entry point system pursuant to ~~sections 26-4-521 to 26-4-525 and this part 6~~ THIS ARTICLE before July 1, 1995, and for all counties on and after said date, means a public or private, nonprofit or for profit agency that meets all applicable state and federal requirements and is certified by the state department to provide case management functions reimbursable under this article AND ARTICLES 4 AND 5 OF THIS TITLE, within a geographic area of the state consisting of one or more counties. Such functions shall be provided by the agency under a contract executed with the state department or other state designated agency. The state department shall establish procedures for the designation, certification, and decertification of case management agencies and requirements for performance and staffing of the agencies. Such procedures and requirements shall be set forth in rules ~~and regulations~~ promulgated by the ~~medical services~~ STATE board or shall be included in the contracts executed by the state department.

(6) "Case management services" means functions performed by a case management agency, including: The assessment of a client's needs, the development and implementation of a case plan for the client, the coordination and monitoring of service delivery, the direct delivery of services as provided by ~~this part 6~~ PARTS 3 TO 12 OF THIS ARTICLE or by rules adopted by the ~~medical services~~ STATE board, the evaluation of service effectiveness, and the reassessment of the client's needs. Case management services shall be reimbursed as an administrative expense.

(7) "Case plan" means a coordinated plan for the provision of long-term-care services in a setting other than a nursing home, developed and managed by a case management agency, in coordination with the client, his family or guardian and physician, and other providers of care.

(8) "Electronic monitoring provider" means an entity ~~which~~ THAT meets applicable state, federal, and local requirements and ~~which~~ is certified to provide electronic monitoring services.

(9) "Electronic monitoring services" means electronic equipment or adaptations ~~which~~ THAT are related to an eligible person's physical impairment and ~~which~~ enable the person to remain at home.

(10) "Homemaker agency" means any agency ~~which~~ THAT meets applicable state and federal requirements and ~~which~~ is state-certified to provide homemaker services.

(11) "Homemaker services" means general household activities ~~which~~ THAT are provided by state-certified agencies to maintain a healthy and safe home environment for eligible persons.

(12) "Home modification provider" means an entity ~~which~~ THAT meets applicable state, federal, and local requirements and ~~which~~ is certified to provide home modification services.

(13) "Home modification services" means home installations or adaptations ~~which~~ THAT are related to the eligible person's physical impairment and ~~which~~ enable the person to remain at home.

~~(13.5)~~ (14) "Medications administration" means the administration or monitoring of medications provided in a manner consistent with part 3 of article 1.5 of title 25, C.R.S., under the authority and direction of the state department, as part of the "alternative care services", as defined in subsection (4) of this section, as provided in an "alternative care facility", as defined in subsection (3) of this section.

~~(14)~~ (15) "Nonmedical transportation provider" means an entity ~~which~~ THAT meets applicable state and federal requirements and ~~which~~ is certified to provide nonmedical transportation services.

~~(15)~~ (16) "Nonmedical transportation services" means transportation of eligible persons to services such as, but not limited to, adult day care services, which enable the person to remain at home.

~~(16)~~ (17) "Personal care agency" means any agency ~~which~~ THAT meets state and federal requirements and ~~which~~ is state-certified to provide personal care services.

~~(17)~~ (18) "Personal care services" means services to meet an eligible person's physical requirements and functional needs, when such services do not require the supervision of a nurse.

~~(18)~~ (19) "Respite care provider" means a facility or agency that meets all

applicable state and federal requirements and is state-certified to provide respite care services.

~~(19)~~ (20) "Respite care services" means services of a short-term nature provided to a client, in the home or in a facility approved by the state department, in order to temporarily relieve the family or other home providers from the care and maintenance of such client, including room and board, maintenance, personal care, and other related services.

~~(20)~~ (21) "Transition coordination service agency" means an agency that is certified by the state department, as specified in rule by the state board, and provides independent living core services as defined in section 26-8.1-102 (3), C.R.S., and community transition services.

25.5-6-304. [Formerly 26-4-604] Administration. The provisions of this ~~subpart~~ PART 3 shall be administered by the state department.

25.5-6-305. [Formerly 26-4-605] Provision of services for elderly, blind, and disabled persons. The provision of the services set forth in this ~~subpart~~ PART 3 shall be subject to the availability of federal matching medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended, for payment of the costs for administration and costs for the provision of such services.

25.5-6-306. [Formerly 26-4-606] Eligible groups. (1) Home- and community-based services under this ~~subpart~~ PART 3 shall be offered only to persons:

- (a) Who are elderly, blind, or physically disabled; and
- (b) Who are in need of the level of care available in a nursing home; and
- (c) Who are categorically eligible for medical assistance, or whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, and whose resources do not exceed the limit established for individuals receiving a mandatory minimum state supplementation of supplemental security income benefits or, in the case of a person who is married, do not exceed the amount authorized in section ~~26-4-506~~ 25.5-6-101.

~~(d) Repealed.~~

(2) A long-term-care eligible person receiving home- and community-based services shall remain eligible for the services specified in sections ~~26-4-202, 26-4-203, 26-4-302, and 26-4-303~~, 25.5-5-102, 25.5-5-103, 25.5-5-202, AND 25.5-5-203, as applicable.

~~(3) Repealed.~~

25.5-6-307. [Formerly 26-4-607] Services for the elderly, blind, and disabled. (1) Subject to the provisions of this ~~subpart~~ PART 3, home- and community-based services for the elderly, blind, and disabled shall include only the following services:

- (a) Adult day care;
- (b) Alternative care services;
- ~~(c) (Deleted by amendment, L. 93, p. 1067, § 13, effective June 3, 1993.)~~
- ~~(d)~~ (c) Electronic monitoring services;
- ~~(e)~~ (d) Home modification services;
- ~~(f)~~ (e) Homemaker services;
- ~~(g)~~ (f) Nonmedical transportation services;
- ~~(h)~~ (g) Personal care services;
- ~~(i)~~ (h) Respite care services;

~~(j)~~ (i) Community transition services not to exceed two thousand dollars per eligible person, unless otherwise authorized by the state department, which shall be administered by a transition coordination service agency;

~~(k)~~ (j) Services provided under the consumer-directed care service model, ~~part 13~~ PART 11 of this article.

(2) All providers of home- and community-based services for the elderly, blind, and disabled may be separately certified to provide other services, if otherwise qualified.

(3) A case management agency may be certified to provide the services described in subsection (1) of this section, if otherwise qualified as a provider under the state medical assistance program.

(4) (a) The case management agency, in coordination with the eligible person, the person's family or guardian, and the person's physician, shall include in each case plan a process by which the eligible person may receive necessary care, which may include respite care, if the eligible person's family or service provider is unavailable due to an emergency situation or to unforeseen circumstances. The eligible person and the person's family or guardian shall be duly informed by the case management agency of these alternative care provisions at the time the case plan is initiated.

(b) The requirements of this subsection (4) shall not apply if the eligible person is residing in an alternative care facility.

25.5-6-308. [Formerly 26-4-607.5] Cost of services. Home- and community-based services for the elderly, blind, and disabled shall meet aggregate federal waiver budget neutrality requirements.

25.5-6-309. [Formerly 26-4-608] Special provisions - post-eligibility treatment of income. Persons who receive services under this ~~subpart 1~~ PART 3 shall pay to the state department, or designated agent or provider, all income

remaining after application of federally allowed maintenance and medical deductions or shall pay the cost of home- and community-based services rendered, whichever is less.

25.5-6-310. [Formerly 26-4-609] Special provisions - personal care services provided by a family. (1) A member of an eligible person's family, other than the person's spouse, may be employed to provide personal care services to such person.

(2) The maximum reimbursement for the services provided by a member of the person's family per year for each client shall not exceed the equivalent of four hundred forty-four service units per year for a member of the eligible person's family.

25.5-6-311. [Formerly 26-4-610] Duties of state department. (1) The state department shall:

~~(a) Repealed:~~

~~(b)~~ (a) Seek and utilize any available federal, state, or private funds which are available for carrying out the purposes of this ~~subpart 1~~ PART 3, including but not limited to medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended;

~~(c)~~ (b) Provide a system for reimbursement for services provided pursuant to this ~~subpart 1~~ PART 3, which system shall encourage cost containment.

25.5-6-312. [Formerly 26-4-611] Gifts - grants. The state department, acting for and on behalf of the state, may receive and accept title to any grant or gift from any source, including the federal government, and all grants, grants-in-aid, and gifts shall be deposited with the state treasurer, who shall credit the same to the general fund, and such moneys shall be appropriated to the state department to carry out the purposes of this article AND ARTICLES 4 AND 5 OF THIS TITLE.

25.5-6-313. [Formerly 26-4-612] Rules - federal authorization. (1) Pursuant to article 4 of title 24, C.R.S., the state board shall adopt rules for the administration of this ~~subpart 1~~ PART 3.

(2) The state department is authorized to seek any necessary federal authorization to implement the provisions of this ~~subpart 1~~ PART 3.

PART 4

HOME- AND COMMUNITY-BASED SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

25.5-6-401. [Formerly 26-4-621] Short title - citation. ~~This subpart 2 shall be comprised of sections 26-4-621 to 26-4-631 and may be cited as subpart 2. The title of this subpart 2~~ THIS PART 4 shall be known and may be cited as the "Home- and Community-based Services for Persons with Developmental Disabilities Act".

25.5-6-402. [Formerly 26-4-622] Legislative declaration. (1) The general assembly hereby finds and declares that it is the purpose of this ~~article~~ PART 4 to

provide services for persons with developmental disabilities which would foster the following goals:

(a) To maintain eligible persons in the most appropriate settings possible and to minimize admissions to institutions;

(b) To recognize the unique services requirements of persons with developmental disabilities;

(c) To provide optimum accessibility to various important social, habilitative, remedial, residential, and health services that are available to assist in maintaining eligible persons in the least restrictive settings;

(d) To provide eligible persons who have the capacity to remain outside an institutional setting access to appropriate social, habilitative, remedial, residential, and health services, without which institutionalization would be necessary;

(e) To provide the most efficient and effective use of funds in the delivery of these social, habilitative, remedial, residential, and health services to eligible persons;

(f) To coordinate, integrate, and link these social, habilitative, remedial, residential, and health services into existing community-based service delivery systems for persons with developmental disabilities, to avoid unnecessary and expensive duplication of services;

(g) To allow the state substantial flexibility in organizing and administering the delivery of social, habilitative, remedial, residential, and health services to eligible citizens.

(2) The general assembly intends that the STATE department of ~~health care policy and financing~~ and the department of human services shall cooperate to the maximum extent possible in designing, implementing, and administering the programs authorized under this ~~subpart 2~~ PART 4.

(3) Nothing in this ~~subpart 2~~ PART 4 shall be construed to disqualify persons from receiving any benefits to which they would otherwise be eligible under ~~parts 2 and 3 of this article~~ PARTS 1 AND 2 OF ARTICLE 5 OF THIS TITLE, or under Title XIX of the federal "Social Security Act", as amended, by reason of being designated as a person with developmental disabilities.

25.5-6-403. [Formerly 26-4-623] Definitions. As used in this ~~subpart 2~~ PART 4, unless the context otherwise requires:

(1) "Developmentally disabled person" means a person with a developmental disability as defined in section 27-10.5-102, C.R.S.

(2) (a) "Eligible person" means a person with developmental disabilities:

(I) Who meets the definition of categorically needy as defined in section ~~26-4-103 (3)~~ 25.5-4-103 (4);

(II) Who is in need of the level of care available in an intermediate care facility for the mentally retarded;

(III) Whose gross income does not exceed three hundred percent of the current federal supplemental security income benefits level or other applicable standard provided in federal regulations construing the federal "Social Security Act", as amended, and whose resources do not exceed the limit established for individuals receiving a mandatory minimum state supplementation of supplemental security income benefits or, in the case of a person who is married, do not exceed the amount authorized in section ~~26-4-506~~ 25.5-6-101; and

(IV) For whom it is determined that provision of such services is necessary to avoid placement in an intermediate care facility for the mentally retarded.

(b) The amount of parental income and resources that shall be attributable to a child's gross income for purposes of eligibility under paragraph (a) of this subsection (2) shall be set forth in rules promulgated by the ~~department~~ STATE BOARD of human services CREATED IN SECTION 26-1-107, C.R.S.

~~(2.5)~~ (3) "In-home services" means those services described in section 27-10.5-406, C.R.S., provided to support individuals living with their family.

~~(3)~~ (4) "Plan of care" means a coordinated plan of care for provision of services in other than a nursing facility or institutional setting, developed and managed, subject to review and approval pursuant to section ~~26-4-624~~ 25.5-6-404, by a community centered board for persons with developmental disabilities. This plan of care shall fully identify the services to be provided to eligible persons. Prior to the provision of those services, a physician may be required to review an assessment document to insure that it adequately describes the medical needs of the eligible person.

~~(4)~~ (5) (a) "Services for persons with developmental disabilities" means those services:

(I) Approved for reimbursement by the federal government; and

(II) Necessary to prevent a person, eligible for services under subsection (2) of this section, from being subjected to placement in an intermediate care facility for the mentally retarded.

(b) "Services for the developmentally disabled" includes, but is not limited to: Social, habilitative, remedial, residential, health services, and services provided under the consumer-directed care service model, ~~part 13~~ PART 11 of this article, which shall include the selection, from a list of qualified entities, of an organization of the eligible person's choice to provide financial management services for the eligible person.

25.5-6-404. [Formerly 26-4-624] Duties of the department of health care policy and financing and the department of human services. (1) The ~~STATE department of health care policy and financing~~ and the department of human services shall provide a system of reimbursement for services provided pursuant to

this ~~subpart 2 which~~ PART 4 THAT encourages the most cost-effective provision of services.

~~(1.5)~~ (2) The STATE department of ~~health care policy and financing~~ and the department of human services shall, subject to appropriation, utilize any available federal, state, local, or private funds, including but not limited to, medicaid funds available under Title XIX of the federal "Social Security Act", as amended, such as medicaid home- and community-based waivers, ~~and model 200 waivers~~ to carry out the purposes of this ~~subpart 2~~ PART 4.

~~(2)~~ (3) The STATE department of ~~health care policy and financing~~ may contract with the department of human services to certify agencies providing services under this ~~subpart 2~~ PART 4 as eligible medicaid providers, to adopt fiscal and administrative procedures, to review plans of care, to set rates, and to make and implement recommendations regarding the scope, duration, and content of programs and the eligibility of persons for specific services provided pursuant to this ~~subpart 2~~ PART 4, and to fulfill any other responsibilities necessary to implement this ~~subpart 2 which~~ PART 4 THAT are consistent with the single state agency designation set out in section ~~26-4-104~~ 25.5-4-104.

~~(3)~~ (4) The executive director and the ~~medical services~~ STATE board shall promulgate such rules ~~and regulations~~ regarding this ~~subpart 2~~ PART 4 as are necessary to fulfill the obligations of the STATE department of ~~health care policy and financing~~ as the single state agency to administer medical assistance programs in accordance with Title XIX of the federal "Social Security Act", as amended. Such rules ~~and regulations~~ may include, but shall not be limited to, determination of the level of care requirements for long-term care, patient payment requirements, clients' rights, medicaid eligibility, and appeal rights associated with these requirements.

~~(4)~~ (5) The ~~department~~ STATE BOARD of human services, CREATED IN SECTION 26-1-107, C.R.S., shall promulgate such rules ~~and regulations~~ as are necessary to implement the provisions of this ~~subpart 2~~ PART 4 and to fulfill the responsibilities and duties set out in article 10.5 of title 27, C.R.S. Such rules ~~and regulations~~ shall be promulgated pursuant to section 24-4-103, C.R.S.

~~(5)~~ (6) In the event that a direct conflict arises between the rules ~~and regulations~~ of the STATE department of ~~health care policy and financing~~ promulgated pursuant to subsection ~~(3)~~ (4) of this section and the rules ~~and regulations~~ of the department of human services promulgated pursuant to subsection ~~(4)~~ (5) of this section, regarding implementation of this ~~subpart 2~~ PART 4, the rules ~~and regulations~~ of the STATE department of ~~health care policy and financing~~ shall control.

25.5-6-405. [Formerly 26-4-625] Relationship to other programs. The provisions of ~~subpart 1 of this part 6~~ PART 3 OF THIS ARTICLE are separate and distinct from the provisions of this ~~subpart 2~~ PART 4. Therefore, the definitions and restrictions embodied in ~~subpart 1 of this part 6~~ PART 3 OF THIS ARTICLE shall not apply to services and programs provided pursuant to this ~~subpart 2~~ PART 4.

25.5-6-406. [Formerly 26-4-626] Appropriations. To carry out duties and obligations pursuant to this ~~subpart 2~~ PART 4 and for the administration and provision of services to eligible persons, all medicaid funds appropriated pursuant

to Title XIX of the federal "Social Security Act", as amended, for the provision of care for persons with developmental disabilities and all other funds otherwise appropriated by the general assembly as additional sources of program funding shall be available for the placement of eligible individuals either in intermediate care facilities for the mentally retarded or alternatives to such placements.

25.5-6-407. [Formerly 26-4-627] Gifts - grants. The STATE department of ~~health care policy and financing~~ and the department of human services, acting on behalf of the state, may receive and accept title to gifts or grants from any source, including the federal government. Both departments shall deposit all grants, grants-in-aid, and gifts with the state treasurer, who shall credit them to the general fund. These moneys shall remain available for appropriation to either department to carry out the purposes of this ~~subpart 2~~ PART 4.

25.5-6-408. [Formerly 26-4-628] Eligibility - fees. (1) Subject to the availability of federal financial participation, services shall be provided to eligible persons pursuant to this ~~subpart 2~~ PART 4.

(2) Any eligible person who accepts and receives services pursuant to this ~~subpart 2~~ PART 4 shall pay to the STATE department, ~~of health care policy and financing~~, or to an agent designated by the STATE department, ~~of health care policy and financing~~, an amount determined pursuant to federal regulations construing the federal "Social Security Act", as amended, concerning the application of patient income to the cost of services.

25.5-6-409. [Formerly 26-4-629] Services for persons with developmental disabilities. (1) A program to provide home- and community-based services to persons with developmental disabilities who are in need of the level of care available in an intermediate care facility for the mentally retarded is hereby established pursuant to the federal "Social Security Act", as amended. This program shall provide for the social, habilitative, remedial, residential, health, and other needs of persons with developmental disabilities to avoid placement in an intermediate care facility for the mentally retarded.

(2) Services for persons with developmental disabilities provided through this program shall be delivered under the provisions of a statewide services plan, in the form of home- and community-based services waivers or model waivers, developed by the STATE department ~~of health care policy and financing~~ and the department of human services and approved by the federal ~~health care financing administration~~ CENTERS FOR MEDICARE AND MEDICAID SERVICES, OR ANY SUCCESSOR AGENCY. This plan shall include the specific services to be offered, a plan for the delivery of such services through community centered boards or other service agencies approved pursuant to article 10.5 of title 27, C.R.S., utilizing where appropriate the provision of in-home services, the expected costs of such services, the expected benefits of providing those services, and the administrative provisions which shall govern the implementation of the plan. The plan shall provide for all necessary safeguards to ~~insure~~ ENSURE the health and welfare of any eligible persons. The average per capita expenditure for services under this plan shall not exceed the average per capita expenditure the department of human services or the STATE department ~~of health care policy and financing~~ would have made for services otherwise available without this plan.

(3) The plan shall utilize existing community-based services programs to the maximum extent possible and shall coordinate all available forms of assistance for the eligible person.

(4) Any services for the developmentally disabled provided through this program shall be set forth in a plan of care developed and managed by a community centered board and subject to review and approval pursuant to section ~~26-4-624~~ 25.5-6-404. The plan of care shall:

(a) Be based on the particular services needs of the eligible person;

(b) Describe the services necessary to avoid institutionalization; and

(c) (I) Include a process by which the person who is receiving services may receive necessary care for medical purposes, which may include respite care, if the person's service provider is unavailable due to an emergency situation or to unforeseen circumstances. The person who is receiving services and the person's family or guardian shall be duly informed by the community centered board of these alternative care provisions at the time the plan of care is initiated.

(II) Nothing in this paragraph (c) requires a community centered board to provide services set forth in a plan of care that the community centered board is not otherwise required to provide to the person receiving services, only that the plan of care include a contingency for such services.

25.5-6-410. [Formerly 26-4-630] Qualification for federal funding. Nothing in this ~~subpart 2~~ PART 4 shall prevent the STATE department of ~~health care policy and financing~~ or the department of human services from complying with federal requirements in order for the state of Colorado to qualify for federal funds under Title XIX of the federal "Social Security Act", as amended.

25.5-6-411. [Formerly 26-4-631] Personal needs trust fund required. All personal needs funds shall be held in trust by a residential facility authorized to provide services pursuant to this ~~subpart 2~~ PART 4, or its designated trustee, separate and apart from any other funds of the facility, in a checking account or savings account or any combination thereof established to protect and separate the personal needs funds of the clients. At all times, the principal and all income derived from said principal in the personal needs trust fund shall remain the property of the participating clients, and the facility or its designated trustee is bound by all of the duties imposed by law upon fiduciaries in the handling of such fund including accounting for all expenditures from the fund.

PART 5

HOME- AND COMMUNITY-BASED SERVICES FOR PERSONS WITH HEALTH COMPLEXES RELATED TO ACQUIRED IMMUNE DEFICIENCY SYNDROME

25.5-6-501. [Formerly 26-4-641] Short title - citation. ~~This subpart 3 shall be comprised of sections 26-4-641 to 26-4-648 and may be cited as subpart 3. The title of this subpart 3~~ THIS PART 5 shall be known and may be cited as the "Home- and Community-based Services for Persons with Health Complexes Related to Acquired

Immune Deficiency Syndrome Act".

25.5-6-502. [Formerly 26-4-642] Definitions. In addition to the definitions in section ~~26-4-603~~ 25.5-6-303, as used in this ~~subpart 3~~ PART 5, unless the context otherwise requires:

(1) "AIDS" means acquired immune deficiency syndrome.

~~(2) (Deleted by amendment, L. 95, p. 297, § 1, effective April 21, 1995.)~~

~~(3)~~ (2) "Continuum of long-term care" shall include all the services listed in section ~~26-4-645~~ 25.5-6-505 and may include brief inpatient stays in a hospital or a nursing facility.

~~(3.2)~~ (3) "HIV" means the human immunodeficiency virus.

~~(3.5)~~ (4) "HIV/AIDS" means:

(a) A symptomatic HIV infection, as defined by the centers for disease control of the United States public health service; or

(b) AIDS.

~~(4) and (5) Repealed.~~

~~(6)~~ (5) "Long-term-care eligible person" means a person who is determined to be:

(a) Eligible to receive services under sections ~~26-4-202, 26-4-203, 26-4-302, and 26-4-303~~ 25.5-5-102, 25.5-5-103, 25.5-5-202, AND 25.5-5-203; and

(b) In need of the level of care available in a nursing facility or in need of the level of care available in a hospital.

25.5-6-503. [Formerly 26-4-643] Administration. The provisions of this ~~subpart 3~~ PART 5 shall be administered by the state department.

25.5-6-504. [Formerly 26-4-644] Program established - financial eligibility.
(1) In recognition of the social and economic benefits accruing from the maintenance of persons with HIV/AIDS in their own homes, the general assembly hereby finds and declares that a program shall be implemented by the state department to provide the services set forth in section ~~26-4-645~~ 25.5-6-505 to those persons with HIV/AIDS whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, whose resources do not exceed the limit established by the state department for individuals receiving a mandatory minimum state supplementation of SSI benefits pursuant to section 26-2-204, C.R.S., or, in the case of a person who is married, do not exceed the amount authorized in section ~~26-4-506~~ 25.5-6-101, and for whom a licensed physician certifies that such program provides an appropriate alternative to institutionalized care.

(2) Any person who accepts and receives services authorized under this ~~subpart~~

~~3~~ PART 5 shall pay to the state department, or to an agent or provider designated by the state department, an amount that shall be the lesser of the person's gross income, minus federally allowed maintenance and medical deductions, or the projected cost of services to be rendered to the person under the case plan. Such amount shall be reviewed and revised as necessary each time the case plan is reviewed.

25.5-6-505. [Formerly 26-4-645] Services for long-term-care eligible persons. (1) Subject to the provisions of this ~~subpart 3~~ PART 5, the home- and community-based services program for persons with HIV/AIDS shall include the following continuum of long-term care services:

~~(a) (Deleted by amendment, L. 93, p. 1067, § 14, effective June 3, 1993.)~~

~~(b)~~ (a) Personal care and homemaker services;

~~(c) (Deleted by amendment, L. 93, p. 1067, § 14, effective June 3, 1993.)~~

~~(d)~~ (b) Adult day care services;

~~(e) (Deleted by amendment, L. 93, p. 1067, § 14, effective June 3, 1993.)~~

~~(f)~~ (c) Private duty nursing services;

~~(g) (Deleted by amendment, L. 95, p. 915, § 13, effective May 25, 1995.)~~

~~(h)~~ (d) Electronic monitoring services as such term is defined in section ~~26-4-603~~ ~~(9)~~ 25.5-6-303 (9);

~~(i)~~ (e) Nonmedical transportation services as such term is defined in section ~~26-4-603 (15)~~ 25.5-6-303 (16);

~~(j)~~ (f) Services provided under the consumer-directed care model, ~~part 13~~ PART 11 of this article.

(2) A long-term-care eligible person receiving home- and community-based services shall remain eligible for the services specified in sections ~~26-4-202, 26-4-203, 26-4-302, and 26-4-303,~~ 25.5-5-102, 25.5-5-103, 25.5-5-202, AND 25.5-5-203, as applicable.

(3) The provision of the services set forth in subsection (1) of this section shall be subject to the availability of federal matching medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended, for payment of the costs for administration and costs for the provision of such services. Case management services shall be reimbursed as an administrative cost.

(4) If the state department or the case management agency makes a determination that the cost for the provision of home- and community-based services necessary to allow an HIV/AIDS client to avoid institutionalization exceeds or would exceed either the average individual medicaid payment for like services for hospital care for clients needing a hospital level of care or the average individual medicaid payment for like services for nursing facility care for clients needing a nursing facility level

of care, such client shall not be considered eligible for home- and community-based services.

(5) The location for the provision of home- and community-based services shall be agreed upon by the HIV/AIDS client and the case management agency.

(6) The state department shall implement the provisions of subsection (1) of this section on a case-by-case basis as each service becomes available through approved providers.

(7) No service listed in subsection (1) of this section may be provided to an eligible person unless authorized pursuant to a case plan.

(8) (a) The case management agency, in coordination with the eligible person and the person's family or guardian, shall include in each case plan a process by which the eligible person may receive necessary care, which may include respite care, if the eligible person's family or service provider is unavailable due to an emergency situation or to unforeseen circumstances. The eligible person and the person's family or guardian shall be duly informed by the case management agency of these alternative care provisions at the time the case plan is initiated.

(b) The requirements of this subsection (8) shall not apply if the eligible person is residing in a nursing facility or an alternative care facility.

25.5-6-506. [Formerly 26-4-645.5] Special provisions - personal care services provided by a family. (1) A member of an eligible person's family, other than the person's spouse, may be employed to provide personal care services to such person.

(2) The maximum reimbursement for the services provided by a member of the person's family per year for each client shall not exceed the equivalent of four hundred forty-four service units per year for a member of the eligible person's family.

25.5-6-507. [Formerly 26-4-646] Duties of state department. (1) In addition to the duties set forth in section ~~26-4-610~~ 25.5-6-311, the state department shall:

(a) Seek and utilize any available federal, state, or private funds which are available for carrying out the purposes of this ~~subpart 3~~ PART 5, including but not limited to medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended;

(b) Provide a system for reimbursement for services provided pursuant to this ~~subpart 3, which system shall encourage~~ PART 5 THAT ENCOURAGES cost containment;

(c) Conduct feasibility studies and pilot programs as the general assembly may from time to time direct to lessen medical costs, including medicaid moneys, associated with persons with HIV/AIDS.

~~(d) Repealed.~~

(2) Prior to the submittal of the home- and community-based services medicaid waiver application for this ~~subpart 5~~ PART 5, the state department shall consult with the joint budget committee of the general assembly concerning the proposed number of clients to be served, the savings anticipated, and the costs associated with the implementation of this program.

25.5-6-508. [Formerly 26-4-648] Rules. The executive director and the ~~medical services~~ STATE board shall promulgate such rules, ~~and regulations~~, pursuant to article 4 of title 24, C.R.S., as are necessary to implement this ~~subpart 5~~ PART 5.

PART 6
HOME- AND COMMUNITY-BASED SERVICES FOR
PERSONS WITH MAJOR MENTAL ILLNESSES

25.5-6-601. [Formerly 26-4-671] Short title - citation. ~~This subpart 5 shall be comprised of sections 26-4-671 to 26-4-676 and may be cited as subpart 5. The title of this subpart 5~~ THIS PART 6 shall be known and may be cited as the "Home- and Community-based Services for Persons with Major Mental Illnesses Act".

25.5-6-602. [Formerly 26-4-672] Legislative declaration - no entitlement created. (1) The general assembly hereby finds and declares that the purpose of this ~~subpart 5~~ PART 6 is to provide, under federal authorization and subject to available appropriations, home- and community-based services for persons with major mental illnesses.

(2) Nothing in this ~~subpart 5~~ PART 6 shall be construed to establish that eligible persons as defined in section ~~26-4-673~~ (1) 25.5-6-603 (1) are entitled to receive services from the STATE department ~~of health care policy and financing~~ or the department of human services. The provision of any services pursuant to this ~~subpart 5~~ PART 6 shall be subject to federal waiver authorization and available appropriations.

25.5-6-603. [Formerly 26-4-673] Definitions. As used in this ~~subpart 5~~ PART 6, unless the context otherwise requires:

(1) "Eligible person" means a person:

(a) Who has a primary diagnosis of major mental illness, as such term is defined in the diagnostic and statistical manual of mental disorders used by the mental health profession, and includes schizophrenic, paranoid, major affective, and schizoaffective disorders, and atypical psychosis, but does not include dementia, including alzheimer's disease or related disorders;

(b) Who is in need of the level of care available in a nursing facility;

(c) Who is categorically eligible for medical assistance, or whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, and whose resources do not exceed the limit established for individuals receiving a mandatory minimum state supplementation of supplemental security income benefits or, in the case of a person who is married, do not exceed the amount authorized in section ~~26-4-506~~ 25.5-6-101.

~~(d) Repealed.~~

25.5-6-604. [Formerly 26-4-673.5] Cost of services. Home- and community-based services for persons with major mental illnesses shall meet aggregate federal waiver budget neutrality requirements.

25.5-6-605. [Formerly 26-4-674] Relationship to single entry point for long-term care. The home- and community-based services program for persons with major mental illnesses shall not be considered a publicly funded long-term care program for the purposes of sections ~~26-4-521 to 26-4-525~~ 25.5-6-105 TO 25.5-6-107, concerning the single entry point system, unless and until the departments of health care policy and financing and human services provide in the memorandum of understanding between the departments for the inclusion of the program in the single entry point system.

25.5-6-606. [Formerly 26-4-675] Implementation of program for mentally ill authorized - federal waiver - duties of the department of health care policy and financing and the department of human services. (1) The state department is hereby authorized to seek any necessary waiver from the federal government to develop and implement a home- and community-based services program for persons with major mental illnesses. The program shall be designed to provide home- and community-based services to eligible persons. Eligibility may be limited to persons who meet the level of services provided in a nursing facility, and services for eligible persons may be established in ~~medical services~~ STATE board rules to the extent such eligibility criteria and services are authorized or required by federal waiver. The program shall include services provided under the consumer-directed care service model, ~~part 13~~ PART 11 of this article.

(2) The STATE department of ~~health care policy and financing~~ and the department of human services shall provide a system of reimbursement for services provided pursuant to this ~~subpart 5~~ which PART 6 THAT encourages the most cost-effective provision of services.

(3) The STATE department of ~~health care policy and financing~~ and the department of human services shall, subject to appropriation, use available federal, state, local, or private funds, including but not limited to medicaid funds available under Title XIX of the federal "Social Security Act", as amended, to carry out the purposes of this ~~subpart 5~~ PART 6.

(4) The STATE department of ~~health care policy and financing~~ may include in the memorandum of understanding with the department of human services provisions that allow the department of human services to certify agencies as medicaid providers for the purposes of this ~~subpart 5~~ PART 6, to adopt fiscal and administrative procedures, to review plans of care, to recommend reimbursement rates, to make recommendations regarding the scope, duration, and content of programs and the eligibility of persons for specific services provided pursuant to this ~~subpart 5~~ PART 6, and to fulfill any other responsibilities necessary to implement this ~~subpart 5~~ PART 6. However, the provisions shall be consistent with the designation of the STATE department of ~~health care policy and financing~~ as the single state agency in section ~~26-4-104~~ 25.5-4-104.

(5) The executive director and the ~~medical services~~ STATE board shall promulgate such rules ~~and regulations~~ regarding this ~~subpart 5~~ PART 6 as are necessary to fulfill the obligations of the STATE department of ~~health care policy and financing~~ as the single state agency to administer medical assistance programs in accordance with Title XIX of the federal "Social Security Act", as amended.

(6) The department of human services shall promulgate such rules as are necessary to perform its function pursuant to this ~~subpart 5~~ PART 6. Such rules shall be promulgated in accordance with section 24-4-103, C.R.S., and shall be consistent with the rules of the executive director and the ~~medical services~~ STATE board.

(7) In the event a direct conflict arises between the rules ~~and regulations~~ of the STATE department of ~~health care policy and financing~~ promulgated pursuant to subsection (5) of this section and the rules ~~and regulations~~ of the department of human services promulgated pursuant to subsection (6) of this section, regarding implementation of this ~~subpart 5~~ PART 6, the rules ~~and regulations~~ of the STATE department of ~~health care policy and financing~~ shall control.

25.5-6-607. [Formerly 26-4-676] Implementation of part contingent upon receipt of federal waiver. (1) The implementation of this ~~subpart 5~~ PART 6 is conditioned upon the issuance of necessary waivers by the federal government and available appropriations. The provisions of this ~~subpart 5~~ PART 6 shall be implemented to the extent authorized by federal waiver. The state department shall propose legislation that conforms with the waiver provisions no later than the next regular legislative session following the issuance of the waiver.

(2) Provisions of this ~~subpart 5~~ PART 6 that are approved by the federal government and are authorized by federal waiver shall remain in effect only for so long as specified in the federal waiver, unless otherwise extended by the federal government. The state department shall provide written notice to the revisor of statutes of the final termination date of the waiver, and this ~~subpart 5~~ PART 6 shall be repealed, effective July 1 of the year in which the waiver is terminated.

~~(3) Repealed.~~

PART 7 HOME- AND COMMUNITY-BASED SERVICES FOR PERSONS WITH BRAIN INJURY

25.5-6-701. [Formerly 26-4-681] Short title - citation. ~~This subpart 6 shall be comprised of sections 26-4-681 to 26-4-685 and may be cited as subpart 6. The title of this subpart 6~~ THIS PART 7 shall be known and may be cited as the "Home- and Community-based Services for Persons with Brain Injury Act".

25.5-6-702. [Formerly 26-4-682] Legislative declaration - no entitlement created. (1) The general assembly hereby finds and declares that the purpose of this ~~subpart 6~~ PART 7 is to provide, under federal authorization and subject to available appropriations, home- and community-based services for persons with brain injury.

(2) Nothing in this ~~subpart 6~~ PART 7 shall be construed to establish that eligible

persons as defined in section ~~26-4-683 (4)~~ 25.5-6-703 (4) are entitled to receive services from the STATE department. ~~of health care policy and financing.~~ The provision of any services pursuant to this ~~subpart 6~~ PART 7 shall be subject to federal waiver authorization and available appropriations.

25.5-6-703. [Formerly 26-4-683] Definitions. As used in this ~~subpart 6~~ PART 7, unless the context otherwise requires:

(1) "Adult day care" means health and social services furnished two or more hours per day on a regularly scheduled basis for one or more days per week in an outpatient setting and for the purpose of ensuring the optimal functioning of the recipient.

(2) "Behavioral programming" means an individualized plan that sets forth strategies to decrease a recipient's maladaptive behaviors that interfere with the recipient's ability to remain in the community. Behavioral programming includes a complete assessment of maladaptive behaviors of the recipient, the development and implementation of a structured behavioral intervention plan, continuous training and supervision of caregivers and behavioral aides, and periodic reassessment of the individualized plan.

(3) "Brain injury" means an injury to the brain arising from external forces including, but not limited to, toxic chemical reactions, anoxia, near drownings, closed or open head injuries, and focal brain injuries.

(4) "Eligible person" means a person:

(a) Who has a diagnosis of brain injury, as such term is defined in subsection (3) of this section;

(b) Who is in need of the level of care available in a hospital, rehabilitation hospital, hospital in lieu of a nursing facility, or is in need of specialized care provided in a nursing facility in lieu of a hospital;

(c) Who is categorically eligible for medical assistance, or has a gross income that does not exceed three hundred percent of the current federal supplemental security income benefit level and resources that do not exceed the limit established for individuals receiving a mandatory minimum state supplementation of supplemental security income benefits or, in the case of a person who is married, do not exceed the amount authorized in section ~~26-4-506~~ 25.5-6-101; and

(d) For whom the cost of services would not exceed the average cost of hospital care.

(5) "Independent living skills training" means skills and therapies that are directed at the development and maintenance of community living skills and community integration. Independent living skills include supervision or training with respect to or assistance with self-care, communication skills, socialization, sensory and motor development, reducing maladaptive behavior, community living and mobility, and therapeutic recreation.

(6) "Personal care services" means assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. Personal care services include assistance with the preparation of meals, but not the cost of the meals, and homemaker services that are necessary for the health and safety of the recipient.

(7) "Structured day treatment" means structured, nonresidential therapeutic treatment services that are directed at the development and maintenance of community living skills and are provided two or more hours per day on a regularly scheduled basis for one or more days per week. Day treatment services include supervision and specific training that allows a recipient to function at the recipient's maximum potential. The services include, but are not limited to, social skills training that allows for reintegration into the community, sensory and motor development services, and services aimed at reducing maladaptive behavior.

(8) "Supported living" means assistance or support designed to maximize or maintain independence and self-direction on a supportive care campus. Supported living services consist of structured interventions designed to provide:

- (a) Protective oversight and supervision;
- (b) Behavioral management and cognitive supports;
- (c) Interpersonal and social skills development;
- (d) Improved household management skills to support independence and community integration; and
- (e) Medical management.

~~(8.5)~~ (9) "Supportive care campus" means a residential campus that provides supported living services.

~~(9)~~ (10) "Transitional living" means a nonmedical residential program that provides training and twenty-four-hour supervision to a recipient over a six-to-twelve-month period that will enhance the recipient's ability to live more independently.

25.5-6-704. [Formerly 26-4-684] Implementation of home- and community-based services program for persons with brain injury authorized - federal waiver - duties of the department. (1) (a) The state department is hereby authorized to seek any necessary waiver from the federal government to develop and implement a home- and community-based services program for persons with brain injury. The state department shall design the program to provide home- and community-based services to eligible persons. Eligibility shall be limited to persons who meet the level of services provided in a hospital, rehabilitation hospital, hospital in lieu of nursing facility care, or who are in need of specialized care provided in a nursing facility in lieu of a hospital.

(b) The state department shall seek any necessary amendments to the current federal waiver for the home- and community-based services program for persons with brain injury to allow supported living, as defined in section ~~26-4-683~~ ~~(8)~~

25.5-6-703 (8), to be provided to eligible persons on a supportive care campus.

(2) Services for eligible persons may be established in department rules to the extent authorized or required by federal waiver, but shall include at least the following:

(a) Independent living skills training, as indicated in the eligible person's plan of care, and provided by local agencies determined by the department to be qualified to provide the services;

(b) Residential care including, but not limited to:

(I) Transitional living;

(II) Respite care;

(III) Supported living;

(c) Personal care services;

(d) Assisted transportation;

(e) Counseling and training including substance abuse treatment and family counseling;

(f) Environmental modification services;

(g) Day care, which may include physical, occupational, and speech therapies as indicated in the eligible person's plan of care;

(h) Structured day treatment, which may include physical, occupational, speech, and cognitive therapies if deemed necessary by the eligible person's case manager and as indicated in the person's plan of care. Structured day treatment services are for individuals who may benefit from continued rehabilitation and reintegration into the community.

(i) Behavioral programming that may be provided in or outside an eligible person's residence;

(j) Assistive technology;

(k) Services provided under the consumer-directed care service model, ~~part 13~~ PART 11 of this article.

~~(2.5)~~ (3) The case manager, in coordination with the eligible person and the person's family or guardian, shall include in each plan of care a process by which the eligible person may receive necessary care, which may include respite care, if the eligible person's family or service provider is unavailable due to an emergency situation or to unforeseen circumstances. The eligible person and the person's family or guardian shall be duly informed by the case manager of these alternative care provisions at the time the plan of care is initiated.

(3) (4) (a) The department shall provide a system of reimbursement for services provided pursuant to this ~~subpart 6~~ PART 7 that encourages the most cost-effective provision of services.

(b) A member of an eligible person's family, other than the person's spouse or a parent of a minor, may be employed to provide personal care services to such person. The maximum reimbursement for the services provided by a member of the person's family per year for an eligible person shall not exceed the equivalent of four hundred forty-four service units per year for a member of the eligible person's family. Standards that apply to other providers who provide personal care services apply to a family member who provides these services. In addition, a registered nurse shall supervise a family member in providing services to the extent indicated in the eligible person's plan of care.

(4) (5) The STATE department shall, subject to appropriation, use available federal, state, local, or private funds including, but not limited to, medicaid funds available under Title XIX of the federal "Social Security Act", as amended, to carry out the purposes of this ~~subpart 6~~ PART 7.

(5) (6) The ~~department~~ STATE BOARD shall adopt rules concerning the certification of agencies as medicaid providers for the purposes of this ~~subpart 6~~ PART 7, fiscal and administrative procedures, procedures for reviewing plans of care, reimbursement rates, and the scope, duration, and content of programs and the eligibility for specific services provided pursuant to this ~~subpart 6~~ PART 7. The ~~department~~ STATE BOARD shall adopt such rules as are necessary to fulfill the obligations of the STATE department as the single state agency to administer medical assistance programs in accordance with Title XIX of the federal "Social Security Act", as amended.

25.5-6-705. [Formerly 26-4-685] Implementation of part contingent upon receipt of federal waiver. (1) (a) The implementation of this ~~subpart 6~~ PART 7 is conditioned upon the issuance of necessary waivers by the federal government and available appropriations. The provisions of this ~~subpart 6~~ PART 7 shall be implemented to the extent authorized by federal waiver. The state department shall propose legislation that conforms with the waiver provisions no later than the next regular legislative session following the issuance of the waiver.

(b) The implementation of the provisions of this ~~subpart 6~~ PART 7 relating to services provided on a supportive care campus are conditioned upon the approval of necessary waiver amendments by the federal government. The provisions of this ~~subpart 6~~ PART 7 relating to supported living shall be implemented to the extent authorized by federal waiver and in accordance with applicable federal requirements.

(2) Provisions of this ~~subpart 6~~ PART 7 that are approved by the federal government and are authorized by federal waiver shall remain in effect only for so long as specified in the federal waiver, unless otherwise extended by the federal government. The state department shall provide written notice to the revisor of statutes of the final termination date of the waiver, and this ~~subpart 6~~ PART 7 shall be repealed, effective July 1 of the year in which the waiver is terminated.

~~(3) Repealed.~~

25.5-6-706. [Formerly 26-4-686] Rate structure - rules - quality assurance.

(1) (a) The ~~medical services~~ STATE board, by rule, shall set tiered per diem rates for services provided on a supportive care campus under this ~~subpart 6~~ PART 7. When structuring the tiered per diem rates, the ~~medical services~~ STATE board shall consider the medical and cognitive needs of eligible persons being served on the supportive care campus.

(b) The maximum per diem rate for the services provided on a supportive care campus shall not exceed the total per diem cost of comparable populations either in institutions or in other community-based settings.

(2) The ~~medical services~~ STATE board shall adopt rules necessary for quality assurance, which shall include certification of supportive care campuses.

PART 8
HOME- AND COMMUNITY-BASED SERVICES
FOR CHILDREN WITH AUTISM

25.5-6-801. [Formerly 26-4-691] Short title. This ~~subpart 7~~ PART 8 shall be known and may be cited as the "Home- and Community-based Services for Children with Autism Act".

25.5-6-802. [Formerly 26-4-692] Definitions. As used in this ~~subpart 7~~ PART 8, unless the context otherwise requires:

(1) "Eligible child" means a child who:

(a) Is eligible for the state's medicaid program pursuant to section ~~26-4-201, 26-4-301, or 26-4-303~~ 25.5-5-101, 25.5-5-201, OR 25.5-5-203;

(b) Is age birth to six years;

(c) Has a diagnosis of autism;

(d) Is at risk of institutionalization in either an intermediate care facility for the mentally retarded, a hospital, or a nursing facility; and

(e) Is not receiving services from any of the alternatives to long-term care waiver programs established in this title.

(2) "Lead provider" means the credentialed, certified, or licensed professional who is the eligible child's primary provider and who is responsible for supervision of the eligible child's care plan.

(3) "Services" means the home- and community-based services provided pursuant to this ~~subpart 7~~ PART 8.

25.5-6-803. [Formerly 26-4-693] Federal authorization - budget neutrality - available appropriations. (1) The state department shall seek the federal

authorization necessary to implement the provisions of this ~~subpart 7~~ PART 8.

(2) Home- and community-based services for children with autism shall meet aggregate federal waiver budget neutrality requirements.

(3) (a) The provision of services pursuant to this ~~subpart 7~~ PART 8 is subject to available appropriations from the Colorado autism treatment fund established in section ~~26-4-695~~ 25.5-6-805.

(b) The provision of home- and community-based services pursuant to this ~~subpart 7~~ PART 8 shall be subject to the availability of federal matching medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended, for payment of the costs for administration and the costs for the provision of such services.

(4) The state department shall:

(a) Seek and utilize any available federal, state, or private funds which are available for carrying out the purposes of this ~~subpart 7~~ PART 8, including but not limited to medicaid funds pursuant to Title XIX of the federal "Social Security Act", as amended.

(b) Provide a system of reimbursement for services that encourages the most cost-effective provision of services.

25.5-6-804. [Formerly 26-4-694] Services - duties of the state department - rules. (1) Subject to the provisions of this ~~subpart 7~~ PART 8, home- and community-based services for children with autism shall include only the following services, as specified in the eligible child's care plan:

(a) Occupational therapy;

(b) Speech therapy;

(c) Psychological and psychiatric services;

(d) Physical therapy;

(e) Behavioral therapy; and

(f) Services provided under the consumer-directed care service model, ~~part 13~~ PART 11 of this article.

(2) No eligible child may receive services in an amount in excess of twenty-five thousand dollars annually.

(3) The state department shall utilize the services of existing service provider agencies to provide services pursuant to this ~~subpart 7~~ PART 8. A service provider agency shall retain no more than fifteen percent of the established service reimbursement rate for administrative costs.

(4) A care planning agency may be certified to provide the services described in subsection (1) of this section if otherwise qualified as a provider under the state medical assistance program.

(5) The state department shall contract with a community centered board for persons with developmental disabilities to serve as the single entry point agency for services and as the care planning agency for eligible children. The care planning process shall include the eligible child's family or guardian, the eligible child's lead provider, and the eligible child's case manager. For the purpose of implementing this ~~subpart 7~~ PART 8 the care planning process shall be coordinated with any other care plan or case manager the eligible child may have.

(6) A member of an eligible child's family may be employed to provide services to the child. The reimbursement limitation in section ~~26-4-609~~ 25.5-6-310 shall not apply to services provided pursuant to this ~~subpart 7~~ PART 8 by a family member.

(7) The state department shall develop the service provisions, which shall include provisions for the supervision of direct care providers, and the care planning process under this ~~subpart 7~~ PART 8 in consultation with parents of children with autism and medical professionals who have expertise in treating children with autism.

(8) The state board shall adopt rules necessary to implement and administer the provisions of this ~~subpart 7~~ PART 8, including but not limited to requiring an ongoing evaluation process for each eligible child and the use of an external evaluation contractor for this purpose.

25.5-6-805. [Formerly 26-4-695] Colorado autism treatment fund. The Colorado autism treatment fund is hereby created and established in the state treasury for the purpose of paying for services provided to eligible children pursuant to this ~~subpart 7~~ PART 8. Such fund shall be comprised of tobacco settlement moneys allocated to such fund. Moneys in the fund shall be subject to annual appropriation by the general assembly for the purposes of this ~~subpart 7~~ PART 8. At the end of any fiscal year, all unexpended and unencumbered moneys in the fund shall remain therein and shall not be credited or transferred to the general fund or any other fund. Any moneys in the fund not expended for the purpose of this ~~subpart 7~~ PART 8 may be invested by the state treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund.

PART 9

HOME- AND COMMUNITY-BASED SERVICE PROGRAMS FOR CHILDREN

25.5-6-901. [Formerly 26-4-509] Disabled children care program - eligibility criteria - documentation requirements - report to the general assembly.

(1) The general assembly hereby finds and declares that a program shall be established by the state department to provide services not otherwise available to eligible disabled children outside the confines of an acute care hospital or nursing facility. Such program shall be known as the "disabled children care program" and shall be designed to safely provide services to eligible disabled children in a home- or community-based setting at a cost to the medicaid program equal to or less than

the medicaid cost of inpatient hospital or nursing facility care.

(2) (a) The state department is authorized to seek a waiver from the federal department of health and human services to qualify for federal financial participation in the disabled children care program. Application for such waiver is contingent upon a finding that continuation of the disabled children care program results in less expenditures from the general fund than if such program were terminated.

(b) If federal financial participation is secured, eligibility for participation in the program and the number of children to be served under the program shall be in accordance with federal regulations.

(3) (a) "Eligible disabled children" means any children eighteen years of age and under who:

(I) Have medical needs which would qualify them, pursuant to state department criteria, for institutionalization or place them at risk for institutionalization in any one of the following: An acute care hospital or a nursing facility; and

(II) Have gross incomes which do not exceed three hundred percent of the current federal supplemental security income benefit level. The amount of parental or spousal income and resources which shall be attributable to a child's gross income for purposes of eligibility shall be set forth in rules and regulations promulgated by the ~~medical services~~ STATE board and shall be in relation to the parent's or spouse's financial responsibility for such child; and

(III) Are not receiving services from any of the alternatives to long-term care waiver programs established under this title.

(b) "Home care services" means all services available under sections ~~26-4-202, 26-4-203, 26-4-302, and 26-4-303~~ which 25.5-5-102, 25.5-5-103, 25.5-5-202, AND 25.5-5-203 THAT may be received in a noninstitutional setting.

(4) (a) The state department shall require the following documentation on each applicant for the program:

(I) An assessment by the disabled child's attending physician of the child's medical, functional, and social status and a determination by such physician that the quality of care which can be provided in the noninstitutional setting is equal to or exceeds the quality of care the child could receive in an acute care hospital or nursing facility;

(II) An analysis of the cost of services for the disabled child in an institutional setting as compared to the cost of such services in a noninstitutional setting;

(III) An assessment of the caregiver's ability to provide the needed services to the disabled child in a noninstitutional setting and an assessment of such caregiver's social history.

(b) The information required under paragraph (a) of this subsection (4) shall be

collected and reviewed by the state department at least every six months for disabled children who enter the disabled children care program in order to ensure that the quality of noninstitutional care continues to equal or exceed such care in an institutional setting and that the costs for care under the program are less than the costs for such care in an institution. When the disabled child is found to no longer qualify for institutionalization or be at risk for institutionalization pursuant to state department criteria, ~~he~~ THE CHILD shall no longer be eligible for the disabled children care program.

25.5-6-902. [Formerly 26-4-509.2] Children's personal assistance services and family support program. (1) The general assembly finds that many families who attempt to care for severely disabled or terminally ill children at home often are burdened with the excessive financial and personal costs of providing continuous care. Private insurance companies rarely support essential, long-term custodial services and often establish monetary limits that are well below the levels required by these disabled children. When coverage is available, care is frequently provided in a medical model that is marginally appropriate to the needs of the children and the family and usually more expensive to the payor. The resulting pressures often contribute to family disintegration and increased dependency on public programs. The general assembly finds that it is in the best interests of the citizens of the state to encourage the preservation of families with children with disabilities.

(2) As used in this section, unless the context otherwise requires, "eligible disabled children" means children eighteen years of age or younger:

(a) Who have medical needs that, pursuant to state department rules, would qualify them for institutionalization or place them at risk of institutionalization in an acute care hospital or nursing facility;

(b) Who have gross incomes, including the amount of parental income and resources to be attributed to the child's gross income according to rules to be promulgated by the ~~medical services~~ STATE board, that do not exceed three hundred percent of the current federal supplemental security income benefit level;

(c) Who are not receiving long-term services from any alternative waiver program established under this title;

(d) For whom a licensed physician has certified that in-home care is an appropriate way to meet the child's needs; and

(e) For whom the cost of care outside of the institution is no higher than the estimated medicaid cost of appropriate institutional care.

(3) There is hereby established in the state department the children's personal assistance services and family support waiver program, referred to in this section as the "program", to provide services to eligible disabled children in their homes rather than in the confines of an acute care hospital or nursing facility. The number of children enrolled in this program or any other model 200 program shall not exceed the state department's ability to cover the costs of the programs within the annual appropriations for this program and any other model 200 program.

(4) Priority for participation in the program shall be given first to children who are on the waiting list for other model 200 programs and secondly to children whose parents will return to work if appropriate care for their disabled child is provided under the program. Spaces in the program shall also be available to children who were already covered by medicaid but who were rendered temporarily ineligible for a period of not more than three months due to a periodic or cyclical peak in their parents' income.

(5) The ~~medical services~~ STATE board shall adopt rules to govern the program consistent with any federal waivers including, but not limited to, rules concerning:

(a) Services that are reimbursable under this section including, but not limited to:

(I) Respite care, to the degree its additional cost is offset by collection of a parental copayment;

(II) Case management; and

(III) Medically necessary professional or community services beyond those specified in section ~~26-4-202 or 26-4-302~~ 25.5-5-102 OR 25.5-5-202, to the degree that they provide a cost-effective and medically appropriate alternative to covered services;

(b) Provider selection and certification;

(c) Documentation for assessment and recertification;

(d) Case management agency selection and responsibility; and

(e) Reimbursement.

~~(5.5)~~ (6) The case management agency, in coordination with the eligible disabled child's family and the child's physician, shall include in each case plan a process by which the eligible disabled child may receive necessary care, which may include respite care, if the eligible disabled child's family or care provider is unavailable due to an emergency situation or to unforeseen circumstances. The eligible disabled child's family shall be duly informed by the case management agency of these alternative care provisions at the time the case plan is initiated.

~~(6)~~ (7) If the state department finds it cost-effective and all necessary federal waivers are obtained, parents of eligible disabled children may be authorized to hire and manage care providers from certified medicaid agencies. Case management agencies shall work with parents to develop the skills necessary for ongoing care management.

~~(7)~~ (8) The state department is authorized to seek waivers from the federal government to qualify for federal financial participation in the program.

~~(8)~~ (9) The state department is authorized to charge and collect copayments from parents for services rendered.

~~(9)~~ (10) The state department is directed to study the advisability of setting an upper limit on parental income for participation in this program and other children's medicaid waiver programs.

PART 10
CONSUMER-DIRECTED ATTENDANT SUPPORT
FOR PERSONS WITH DISABILITIES

25.5-6-1001. [Formerly 26-4-901] Legislative declaration. The general assembly finds that there may be a more effective and efficient way to deliver attendant support services to persons with disabilities that allows for more consumer direction and cost savings to the state. The general assembly finds that the provision of attendant support can allow persons with disabilities to be employed and to live in their homes and that the lack of attendant support has been a barrier to both employment and community living. The general assembly further finds that every person with a disability does not need the same level of supervision from a licensed health care professional in order to receive quality attendant support. The general assembly acknowledges that there may be increased risk associated with relying upon persons with disabilities to self-direct their attendant support; however, the general assembly finds that persons with disabilities should have similar opportunities to succeed and to fail consistent with the experiences of other citizens of this state. The general assembly, therefore, declares that it would be beneficial to the state of Colorado for the state department, in cooperation with the department of human services, to analyze the feasibility and cost-effectiveness of a consumer-directed attendant support program that promotes self-sufficiency, self-reliance, and a sense of personal responsibility in persons with disabilities who make appropriate attendant support decisions.

25.5-6-1002. [Formerly 26-4-902] Definitions. As used in this ~~part 9~~ PART 10, unless the context otherwise requires:

(1) "Attendant support" means any action to assist a person with a disability in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks. Such activities include, but are not limited to, personal care services, household services, cognitive services, mobility services, and health-related tasks.

~~(1.5)~~ (2) "Authorized representative" means an individual designated by the consumer of attendant support, the parent of a minor, or the legal guardian of the consumer of attendant support, if appropriate, who has the judgment and ability to assist the consumer of attendant support in acquiring and utilizing services under this ~~part 9~~ PART 10. The extent of the authorized representative's involvement shall be determined upon designation. The authorized representative shall not be the consumer's service provider.

~~(2)~~ (3) "Consumer-directed" means that a person with a disability receives a direct payment and employs, trains, and in other ways manages the person who provides their attendant support. The direct payment received by a person with a disability to pay for attendant support shall not be counted as income for purposes of determining eligibility for medicaid and other state programs that use income to determine eligibility.

(3)(4) "Person with a disability" means a person who meets the definition of disability set forth in Title I of the federal "Americans with Disabilities Act of 1990", 42 U.S.C. 12101 through 12213, sec. 1630.2 (g).

(4)(5) "Primary care physician" means a physician who is the primary provider of physician services to the person with a disability or who is familiar with the person's needs and capabilities.

25.5-6-1003. [Formerly 26-4-903] Pilot program - consumer-directed attendant support. (1) The general assembly authorizes the state department, in cooperation with the department of human services, to implement a pilot program that would allow persons with disabilities to self-direct their attendant support to the extent authorized by federal waiver. The pilot program shall begin no later than July 1, 1997. The departments shall design and implement a program with input from an advisory committee that shall include consumers of attendant support. The departments are authorized to seek any federal waivers that may be necessary to implement this ~~part 9~~ PART 10.

(2) (a) The purpose of the pilot program authorized by this section shall be to increase the amount of consumer direction in the delivery of attendant support, to increase flexibility in the way attendant support is delivered, and to produce an overall cost savings for the state compared to the estimated expenditures that would have been spent for the same persons with disabilities absent the pilot program.

(b) In order to qualify and to remain eligible for the pilot program authorized by this section, a person with a disability shall:

(I) Be willing to participate in the pilot program;

(II) Be eligible for medicaid. This pilot program may include persons whose gross income does not exceed three hundred percent of the current federal supplement security income benefit level and who are eligible for a home- and community-based program but who choose the pilot program authorized in subsection (1) of this section in lieu of a home- and community-based program.

(III) Demonstrate a current need for attendant support, as defined in rule by the state board;

(IV) Have a utilization review that indicates a predictable need for attendant support and a pattern of stable health, such as a person with a disability who seeks appropriate treatment for illnesses and conditions;

(V) Obtain a statement from his or her primary care physician that indicates such person with a disability has sound judgment, or that such person with a disability has an authorized representative, and is in stable condition;

(VI) Demonstrate the ability to handle the financial aspects of self-directed attendant care or have an authorized representative who is able to handle the financial aspects of self-directed attendant care;

(VII) Demonstrate the ability to manage the health aspects of his or her life or

have an authorized representative to manage the health aspects of the eligible person; and

(VIII) Demonstrate the ability to supervise attendants and to give clear directions or have an authorized representative to supervise attendants and to give clear directions.

(3) The state department and the department of human services shall develop the accountability requirements necessary to safeguard the use of public dollars and to promote effective and efficient service delivery.

(4) The state department and the department of human services shall work with consumers of attendant support to develop training and technical assistance for persons with disabilities who choose to participate in the pilot program authorized by this section. The departments shall determine whether such training is mandatory or optional for participants.

(5) The state ~~department~~ BOARD shall adopt rules as necessary for the implementation and administration of the pilot program authorized by this section. Such rules may include a provision allowing a person with a cognitive disability, such as a person with a developmental disability or person with a mental illness, to designate a family member or friend to be responsible for managing the financial matters associated with the self-directed attendant care. Such designee shall not receive reimbursement for his or her services.

(6) The state department and the department of human services shall conduct an independent evaluation of the pilot program to be completed by the end of the third year and by the end of the sixth year of the program and a report of such evaluation shall be provided to the general assembly by September 1, 2002, December 15, 2005, and December 15, 2008. The report of the evaluation shall include the following:

- (a) The number of persons with disabilities participating in the pilot program;
- (b) The cost-effectiveness of the pilot program;
- (c) Feedback from consumers, the state department, and the department of human services concerning the progress and success of the program;
- (d) Any changes to the health status or health outcomes of the participating recipients;
- (e) Other information relevant to the successes and problems of the pilot program; and
- (f) Recommendations concerning the feasibility of continuing the program beyond the pilot stage and changes, if any, that are needed.

(7) The executive directors of the state department and the department of human services are authorized to accept and expend on behalf of the state any grants or donations from any private source for the purpose of implementing this ~~part~~ PART

10.

(8) ~~Section~~ SECTIONS 12-38.1-117 (1) (b), ~~C.R.S., section~~ 12-38.1-102 (5), ~~C.R.S., section~~ 12-38-123 (1) (a), ~~C.R.S., section~~ 12-38-103 (8), ~~C.R.S., and section~~ 12-38-103 (11), C.R.S., shall not apply to a person who is directly employed by an individual participating in the pilot program pursuant to this section and who is acting within the scope and course of such employment. However, such person may not represent himself or herself to the public as a licensed nurse, a certified nurse aide, a licensed practical or professional nurse, a registered nurse, or a registered professional nurse. This exclusion shall not apply to any person who has had his or her license as a nurse or certification as a nurse aide suspended or revoked or his or her application for such license or certification denied.

(9) A person who has been designated as an authorized representative under this ~~part 9~~ PART 10 shall submit an affidavit, which shall become part of the file of the person with a disability, stating that:

(a) He or she is at least eighteen years of age;

(b) He or she has known the person with a disability for at least two years;

(c) He or she has not been convicted of any crime involving exploitation, abuse, or assault on another person; and

(d) He or she does not have a mental, emotional, or physical condition that could result in harm to the person with a disability.

25.5-6-1004. [Formerly 26-4-904] Repeal of part. This ~~part 9~~ PART 10 is repealed, effective July 1, 2009.

PART 11 CONSUMER-DIRECTED CARE

25.5-6-1101. [Formerly 26-4-1301] Definitions. As used in this ~~part 13~~ PART 11, unless the context otherwise requires:

(1) "Attendant support" means any action to assist an eligible person in accomplishing activities of daily living, instrumental activities of daily living, and habilitative and health-related tasks. Such activities include, but are not limited to, personal care services, household services, cognitive services, mobility services, and health-related tasks.

~~(1.5)~~ (2) "Authorized representative" means an individual designated by the eligible person, by the parent of a minor, or by the legal guardian of the eligible person if the eligible person cannot demonstrate sound judgment to his or her primary care physician, who has the judgment and ability to assist the eligible person in acquiring and utilizing services under this ~~part 13~~ PART 11. The extent of the authorized representative's involvement shall be determined upon designation.

~~(2)~~ (3) "Consumer-directed" means that an eligible person receives a direct payment through a voucher and employs, trains, and in other ways manages the

person who provides his or her attendant support. The direct payment through a voucher that is received by an eligible person to pay for attendant support shall not be counted as income for purposes of determining eligibility for medicaid and other state programs that use income to determine eligibility.

~~(3)~~ (4) "Eligible person" means a person who is eligible to receive services under ~~part 6~~ PARTS 3 TO 12 of this article ~~4 of this title~~ or any other home- and community-based service waiver for which the state department has federal waiver authority.

~~(3.5)~~ (5) "Primary care physician" means a physician who is the primary provider of physician services to the eligible person or who is familiar with the eligible person's needs and capabilities.

~~(4)~~ (6) "Qualified services" means services provided under the eligible person's applicable waiver program and attendant support.

25.5-6-1102. [Formerly 26-4-1302] Service model - consumer-directed care.

(1) The state department shall implement a consumer-directed care service model that allows eligible persons to receive a direct payment through a voucher to purchase qualified services. The state department is authorized to seek any federal waivers or waiver amendments that may be necessary to implement this ~~part 13~~ PART 11. The state department shall design and implement the consumer-directed care service model with input from consumers of home- and community-based services or their authorized representatives. An eligible person shall not be required to disenroll from the person's waiver program in order to receive qualified services through the consumer-directed care service model.

(2) In order to qualify and to remain eligible for the consumer-directed care service model authorized by this section, a person shall:

(a) Be eligible for home- and community-based services under ~~part 6~~ PARTS 3 TO 12 of THIS article ~~4 of this title~~ or any other home- and community-based service waiver for which the state department has federal waiver authority;

(b) Be willing to participate;

(c) Obtain a statement from his or her primary care physician indicating that the person has sound judgment and the ability to direct his or her care or has an authorized representative;

(d) Demonstrate the ability to handle the financial aspects of self-directed care or has an authorized representative who is able to handle the financial aspects of the eligible person's care; and

(e) Meet any other qualifications established by the ~~medical services~~ STATE board by rule.

(3) The voucher issued to the eligible person under this ~~part 13~~ PART 11 shall be based on the eligible person's historical utilization of home- and community-based services under ~~part 6~~ PARTS 3 TO 12 of this article, the single entry point agency's

care plan, or any approved resource allocation process as determined by the state department and the department of human services for the eligible person.

(4) While an eligible person is participating in the consumer-directed care service model established in this ~~part 13~~ PART 11, that person shall be ineligible to receive a home care allowance as provided in section 26-2-122.3 (1) (b), C.R.S.

(5) The state department shall develop the accountability requirements necessary to safeguard the use of public dollars, to promote effective and efficient delivery of services, and to monitor the safety and welfare of eligible persons under this ~~part 13~~ PART 11.

(6) The ~~medical services~~ STATE board shall adopt rules as necessary for the implementation and administration of the consumer-directed care service model authorized by this ~~part 13~~ PART 11. Such rules shall include a provision allowing an eligible person to designate a family member or authorized representative to be responsible for managing the financial matters associated with the consumer-directed care or to direct the eligible person's care. The designee shall not receive reimbursement for managing the financial matters associated with the eligible person's care or for directing the eligible person's care.

(7) Sections 12-38-103 (8), 12-38-103 (11), 12-38-123 (1) (a), 12-38.1-102 (5), and 12-38.1-117 (1) (b), C.R.S., shall not apply to a person who is directly employed by an individual participating in the consumer-directed care service model pursuant to this section and who is acting within the scope and course of such employment. However, such person may not represent himself or herself to the public as a licensed nurse, a certified nurse aide, a licensed practical or professional nurse, a registered nurse, or a registered professional nurse. This exclusion shall not apply to any person who has had his or her license as a nurse or certification as a nurse aide suspended or revoked or his or her application for such license or certification denied.

(8) Section ~~26-4-609~~ 25.5-6-310 does not apply to a family member of an eligible person who provides consumer-directed care services to the eligible person pursuant to this ~~part 13~~ PART 11.

(9) A person who has been designated as an authorized representative under this ~~part 13~~ PART 11 shall submit an affidavit, which shall become part of the eligible person's file, stating that:

- (a) He or she is at least eighteen years of age;
- (b) He or she has known the eligible person for at least two years;
- (c) He or she has not been convicted of any crime involving exploitation, abuse, or assault on another person; and
- (d) He or she does not have a mental, emotional, or physical condition that could result in harm to the eligible person.

25.5-6-1103. [Formerly 26-4-1303] Reporting. (1) The state department shall

provide a report to the joint budget committee of the general assembly and the ~~health, environment, welfare, and institutions~~ HEALTH AND HUMAN SERVICES committees of the house of representatives and the senate, OR ANY SUCCESSOR COMMITTEES, by October 1, 2006, that includes, but is not limited to, the following:

- (a) The number of elderly persons participating in the consumer-directed care program;
- (b) The cost-effectiveness of the consumer-directed care program;
- (c) Feedback from consumers and the state department concerning the progress and success of the consumer-directed care program; and
- (d) Any changes to the health status or health outcomes of the program participants.

PART 12 IN-HOME SUPPORT SERVICES

25.5-6-1201. [Formerly 26-4-1401] Legislative declaration. The general assembly finds that there may be a more effective way to deliver home- and community-based services to the elderly, blind, and disabled and to disabled children that allows for more self direction in their care and a cost savings to the state. The general assembly also finds that every person that is currently receiving home- and community-based services does not need the same level of supervision and care from a licensed health care professional in order to meet his or her care needs and remain living in the community. The general assembly, therefore, declares that it is beneficial to the elderly, blind, and disabled clients of home- and community-based services and to clients of the disabled children care program for the state department to develop a service that would allow these people to receive in-home support.

25.5-6-1202. [Formerly 26-4-1402] Definitions. As used in this ~~part 14~~ PART 12, unless the context otherwise requires:

(1) "Attendant" means a person who is directly employed by an in-home support service agency to provide or a family member providing in-home support services to eligible persons.

(2) "Authorized representative" means an individual designated by the eligible person receiving services, or by the parent or guardian of the eligible person receiving services, if appropriate, who has the judgment and ability to assist the eligible person receiving services in acquiring and utilizing services under this ~~part 14~~ PART 12. The extent of the authorized representative's involvement shall be determined upon designation. The authorized representative shall not be the eligible person's service provider.

(3) "Eligible person" means any person who:

- (a) Is eligible for home- and community-based services under ~~subpart 1 of part 6~~ PART 3 of THIS article ~~4 of this title~~ or is eligible for the disabled children care

program under section ~~26-4-509~~ 25.5-6-901;

(b) Is willing to participate;

(c) Obtains a statement from his or her primary care physician indicating that the person has sound judgment and the ability to direct his or her care, the eligible child's parent or guardian has sound judgment and the ability to direct the eligible child's care, or the person has an authorized representative; and

(d) Meets any other qualifications established by the ~~medical services~~ STATE board by rule.

(4) "Health maintenance activities" means health-related tasks as defined in rule by the state ~~department~~ BOARD and include, but are not limited to, catheter irrigation, administration of medication, enemas, and suppositories, and wound care.

(5) "In-home support service agency" means an agency that is certified by the state department and provides independent living core services as defined in section 26-8.1-102 (3), C.R.S., and in-home support services.

(6) "In-home support services" means services that are provided by an attendant and include health maintenance activities, support for activities of daily living or instrumental activities of daily living, personal care services as defined in section ~~26-4-603 (17)~~ 25.5-6-303 (18), and homemaker services as defined in section ~~26-4-603 (11)~~ 25.5-6-303 (11).

25.5-6-1203. [Formerly 26-4-1403] In-home support services - eligibility - licensure exclusion - in-home support service agency responsibilities. (1) The state department shall offer in-home support services as an option for eligible persons who receive home- and community-based services. In-home support services shall be provided to eligible persons. The state department shall seek any federal authorization that may be necessary to implement this ~~part 14~~ PART 12. The state department shall design and implement in-home support services with input from consumers of home- and community-based services and independent living centers and home- and community-based service providers.

(2) An eligible person receiving in-home support services or the eligible person's authorized representative or parent or guardian shall be allowed to choose the eligible person's in-home support service agency or the eligible person's attendant.

(3) Sections 12-38-103 (8), 12-38-103 (11), 12-38-123 (1) (a), 12-38.1-102 (5), and 12-38.1-117 (1) (b), C.R.S., shall not apply to a person who is directly employed by an in-home support service agency to provide in-home support services and who is acting within the scope and course of such employment or is a family member providing in-home support services pursuant to this ~~part 14~~ PART 12. However, such person may not represent himself or herself to the public as a licensed nurse, a certified nurse aide, a licensed practical or professional nurse, a registered nurse, or a registered professional nurse. This exclusion shall not apply to any person who has had his or her license as a nurse or certification as a nurse aide suspended or revoked or his or her application for such license or certification denied.

(4)(a) In-home support service agencies providing in-home support services shall provide twenty-four-hour back-up services to their clients. In-home support service agencies shall either contract with or have on staff a state licensed health care professional, as defined by the ~~medical services~~ STATE board by rule, acting within the scope of the person's profession. The ~~medical services~~ STATE board shall promulgate rules setting forth the training requirements for attendants providing in-home support services and the oversight and monitoring responsibilities of the state licensed health care professional that is either contracting with or is on staff with the in-home support service agency.

(b) The ~~medical services~~ STATE board shall promulgate rules that establish how an in-home support service agency can discontinue a client under this ~~part 14~~ PART 12. The rules shall establish that a client can only be involuntarily discontinued when equivalent care in the community has been secured or that a client can be discontinued after exhibiting documented prohibited behavior involving attendants, including abuse of attendants, and that dispute resolution has failed. The determination of whether an in-home support service agency has made adequate attempts at resolution shall be made by the state department.

(5) The single entry point agencies established in section ~~26-4-522~~ 25.5-6-106 shall be responsible for determining a person's eligibility for in-home support services; except that for eligible disabled children the state department shall designate the entity that will determine the child's eligibility. The ~~medical services~~ STATE board shall promulgate rules specifying the single entry point agencies' responsibilities under this ~~part 14~~ PART 12. At a minimum, these rules shall require that case managers discuss the option and potential benefits of in-home support services with all eligible long-term care clients.

(6) Section ~~26-4-609~~ 25.5-6-310 does not apply to any parent who provides in-home support services to an eligible disabled child pursuant to this ~~part 14~~ PART 12.

25.5-6-1204. [Formerly 26-4-1404] Provision of services - duties of state department - gifts - grants. (1) The provision of the in-home support services set forth in this ~~part 14~~ PART 12 shall be subject to the availability of federal matching medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended, for payment of the costs for administration and the costs for the provision of such services.

(2) The state department shall seek and utilize any available federal, state, or private funds that are available for carrying out the purposes of this ~~part 14~~ PART 12, including but not limited to medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended.

(3) The executive director of the state department is authorized to accept and expend on behalf of the state any grants or gifts from any public or private source for the purpose of implementing this ~~part 14~~ PART 12.

25.5-6-1205. [Formerly 26-4-1405] Accountability - rate structure - rules. (1) The state department shall develop the accountability requirements necessary to safeguard the use of public dollars and to promote effective and efficient service

delivery under this ~~part 14~~ PART 12.

(2) The ~~medical services~~ STATE board, by rule, shall set a separate rate structure for in-home support services provided under this ~~part 14~~ PART 12.

(3) The ~~medical services~~ STATE board shall adopt rules as necessary for the implementation and administration of the in-home support services authorized by this ~~part 14~~ PART 12. At a minimum, the rules shall include certification of in-home support service agencies and standards of care for the provision of services under this ~~part 14~~ PART 12.

25.5-6-1206. [Formerly 26-4-1406] Report. On or before January 1, 2008, the state department shall provide a report to the joint budget committee of the general assembly and the ~~health, environment, welfare, and institutions~~ HEALTH AND HUMAN SERVICES committees of the house of representatives and the senate, OR ANY SUCCESSOR COMMITTEES, on the implementation of in-home support services. At a minimum the report shall include the cost-effectiveness of providing in-home support services to the elderly, blind, and disabled and to eligible disabled children and the number of persons receiving such services.

25.5-6-1207. [Formerly 26-4-1407] Repeal of part. This ~~part 14~~ PART 12 is repealed, effective July 1, 2008. Prior to such repeal, in-home support services established under this ~~part 14~~ PART 12 shall be reviewed as provided for in section 24-34-104, C.R.S.

25.5-6-1208. [Formerly 26-4-1408] Conditional repeal of part. (1) This ~~part 14~~ PART 12 shall be repealed if sufficient federal funds reflected in section 3 of senate bill 02-027, enacted at the second regular session of the sixty-third general assembly, are not received by the state department. If sufficient federal funds are not received by the state department, said department shall immediately notify the revisor of statutes, IN WRITING.

(2) This ~~part 14~~ PART 12 shall be repealed upon receipt by the revisor of statutes of the notification described in subsection (1) of this section.

ARTICLE 8

Children's Basic Health Plan

25.5-8-101. [Formerly 26-19-101] Short title. This article shall be known and may be cited as the "Children's Basic Health Plan Act".

25.5-8-102. [Formerly 26-19-102] Legislative declaration. (1) The general assembly hereby finds and declares that a significant percentage of children are uninsured. This lack of health insurance coverage decreases children's access to preventive health care services, compromises the productivity of the state's future workforce, and results in avoidable expenditures for emergency and remedial health care. Health care providers, health care facilities, and all purchasers of health care, including the state, bear the costs of this uncompensated care.

(2) The general assembly further finds and declares that the coordination and consolidation of funding sources currently available to provide services to uninsured

children such as the Colorado indigent care program pursuant to ~~article 15~~ PART 1 OF ARTICLE 3 of this title, the children's basic health plan, and other children's health programs would efficiently and effectively meet the health care needs of uninsured children and would help to reduce the volume of uncompensated care in the state.

(3) (a) It is the intent of the general assembly to make health insurance coverage available and affordable and to support employers in their efforts to provide their employees and their dependents with health insurance coverage and to support increased availability of affordable health insurance in the individual market.

(b) It is the intent of the general assembly that the savings and efficiencies realized through actual reductions in administrative and programmatic costs associated with the implementation of this article and achieved in consolidating other health care programs should be identified.

(4) It is not the intent of the general assembly to create an entitlement for health insurance coverage.

(5) The general assembly hereby declares that the following principles shall be used in implementing the children's basic health plan set forth in this article:

(a) The department shall establish and maintain a goal of inter-program communication in order to maximize existing state appropriations for the population served in the program;

(b) There shall be efficient program utilization through inter-program coordination and program consolidation and, where appropriate, through contracting with the private sector and with essential community providers;

(c) The policies enacted in House Bill 97-1304 regarding a strong managed care direction shall be emphasized;

(d) The private sector shall be involved to the greatest possible degree with respect to contracting for managed care;

(e) There shall be maximum emphasis on coordination with local and state public health programs and initiatives for children.

(6) The general assembly hereby finds and declares:

(a) That the goal of the "Children's Basic Health Plan Act" is to support low-income, working parents and families in overcoming barriers in obtaining good quality, affordable health care services for their children;

(b) That the health services that low-income children receive through the children's basic health plan should be cost-effective, of high quality, and promote positive health outcomes for enrolled children;

(c) That the children's basic health plan was designed as, and should continue to be, a private-public partnership that encourages enrollment and seeks every opportunity to operate with the efficiency and creativity that is found in utilizing

private sector systems and business practices while maintaining the highest level of accountability to the general assembly, the executive branch, and the public through administration of the plan by the department; ~~of health care policy and financing;~~

(d) That the children's basic health plan was designed as, and should continue to be, a community-based program that encourages local participation in enrolling children in and supporting its goals.

25.5-8-103. [Formerly 26-19-103] Definitions. As used in this article, unless the context otherwise requires:

(1) "Child" means a person who is less than nineteen years of age.

(2) "Children's basic health plan" or "plan" means the subsidized health insurance product designed by the department of health care policy and financing and provided to enrollees, as defined in this section.

(3) "Department" means the department of health care policy and financing created in section 25.5-1-104. ~~C.R.S.~~

(4) "Eligible person" means:

(a) A person who is less than nineteen years of age, whose family income does not exceed two hundred percent of the federal poverty level, adjusted for family size; or

(b) A pregnant woman whose family income does not exceed two hundred percent of the federal poverty level, adjusted for family size, and who is not eligible for medicaid.

(5) "Enrollee" means any eligible person that has enrolled in the plan.

~~(5.4)~~ (6) "Essential community provider" means a health care provider that:

(a) Has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low-income and medically indigent populations who make up a significant portion of its patient population, or in the case of a sole community provider, serves the medically indigent patients within its medical capability; and

(b) Waives charges or charges for services on a sliding scale based on income and does not restrict access or services because of a client's financial limitations.

~~(6)~~ (7) "Health care program" means any health care program in the state that is supported with state general fund or federal dollars.

~~(6.3)~~ (8) "Master settlement agreement" means the master settlement agreement, the smokeless tobacco master settlement agreement, and the consent decree approved and entered by the court in the case denominated *State of Colorado, ex rel. Gale A. Norton, Attorney General v. R.J. Reynolds Tobacco Co.; American Tobacco Co., Inc.; Brown & Williamson Tobacco Corp.; Liggett & Myers, Inc.;*

Lorillard Tobacco Co., Inc.; Philip Morris, Inc.; United States Tobacco Co.; B.A.T. Industries, P.L.C.; The Council For Tobacco Research--U.S.A., Inc.; and Tobacco Institute, Inc., Case No. 97 CV 3432, in the district court for the city and county of Denver.

~~(6.4)~~ (9) "Medical services board" means the medical services board created in section 25.5-1-301. ~~C.R.S.~~

~~(6.5) Repealed.~~

~~(7)~~ (10) "Subsidized enrollee" means an eligible person who receives a subsidy from the department to purchase coverage under the plan or a comparable health insurance.

~~(8)~~ (11) "Subsidy" means the amount paid by the department to assist an eligible person in purchasing coverage under the plan or a comparable health insurance product available to the eligible person through another coverage entity.

~~(9)~~ (12) "Trust" means the children's basic health plan trust created in section ~~26-19-105~~ 25.5-8-105.

25.5-8-104. [Formerly 26-19-104] Children's basic health plan - rules. The medical services board is authorized to adopt rules to implement the children's basic health plan to provide health insurance coverage to eligible persons on a statewide basis pursuant to the provisions of this article. Any rules adopted by the children's basic health plan policy board in accordance with the requirements of the "State Administrative Procedure Act", article 4 of title 24, C.R.S., shall be enforceable and shall be valid until amended or repealed by the medical services board.

25.5-8-105. [Formerly 26-19-105] Trust - created. (1) A fund to be known as the children's basic health plan trust is hereby created and established in the state treasury. Except as provided for in subsection ~~(2.7)~~ (4) of this section, all moneys deposited in the trust and all interest earned on moneys in the trust shall remain in the trust for the purposes set forth in this article, and no part thereof shall be expended or appropriated for any other purpose.

(2) Except as provided for in subsection ~~(2.7)~~ (4) of this section, all or a portion of the moneys in the trust shall be annually appropriated by the general assembly for the purposes of this article and shall not be transferred to or revert to the general fund of the state at the end of any fiscal year.

~~(2.5)~~ (3) Pursuant to section 24-75-1104.5 (1) (c), C.R.S., beginning in the 2004-05 fiscal year and in each fiscal year thereafter so long as the state receives moneys pursuant to the master settlement agreement, the general assembly shall appropriate to the trust twenty-four percent of the total amount of the moneys annually received by the state pursuant to the master settlement agreement, not including attorney fees and costs, during the preceding fiscal year; except that the amount so appropriated to the trust shall not exceed thirty million dollars in any fiscal year. Except as otherwise provided in sections 24-22-115.5 (2) (a.7) and 24-75-1104.5 (1) (c), C.R.S., the general assembly shall appropriate the amount specified in this subsection ~~(2.5)~~ (3) from moneys credited to the tobacco litigation

settlement cash fund created in section 24-22-115, C.R.S. The amount appropriated pursuant to this subsection ~~(2.5)~~ (3) shall be in addition to and not in replacement of any general fund moneys appropriated to the trust.

~~(2.7)~~ (4) On June 30, 2006, the state treasurer and the controller shall transfer eight million one hundred thousand dollars from the trust to the state general fund.

~~(3)~~ (5) (a) Beginning in fiscal year 1998, appropriations to the trust may be made by the general assembly based on the savings achieved through reforms, consolidations, and streamlining of health care programs realized through actual reductions in administrative and programmatic costs associated with the implementation of this article and not decreases in the number of caseloads of such programs. Beginning with and subsequent to fiscal year 2000-01, the general assembly may make annual appropriations to the trust.

(b) (I) Notwithstanding any provision of paragraph (a) of this subsection ~~(3)~~ (5) to the contrary, on March 27, 2002, the state treasurer shall deduct nine hundred thousand dollars from the trust and transfer such sum to the general fund.

(II) In order to restore the amount transferred from the trust pursuant to subparagraph (I) of this paragraph (b), moneys from the general fund shall be transferred to the trust in accordance with section 24-75-217, C.R.S.

(c) Notwithstanding any provision of this section to the contrary, on March 5, 2003, the state treasurer shall deduct from the trust, out of moneys appropriated pursuant to section 24-75-1104 (1) (b) (II), C.R.S., two million one thousand one hundred twenty-five dollars, and transfer such sum to the general fund.

~~(4)~~ (6) As part of its annual savings report to the general assembly on November 1 of each year, the department may identify efficiencies and consolidations that produce savings in the department's annual budget request that result in actual reductions in administrative and programmatic costs associated with the implementation of this article and not decreases in the number of caseloads of such programs. These identified savings shall not duplicate the savings reported in the annual savings report described in section ~~26-19-106~~ 25.5-8-106.

~~(5)~~ (7) The department may receive payment for coverage offered and may receive or contract for donations, gifts, and grants from any source. Such funds shall be transmitted to the state treasurer who shall credit the same to the trust. The department may expend such funds from the trust for the purposes of this article.

25.5-8-106. [Formerly 26-19-106] Annual savings report. (1) By October 1 of each year, the department shall submit to the joint budget committee of the general assembly, to the ~~health, environment, welfare, and institutions~~ HEALTH AND HUMAN SERVICES committees of the house of representatives and the senate, OR ANY SUCCESSOR COMMITTEES, and to the office of state planning and budgeting an annual savings report stating the cost-savings anticipated in the previous, current, and subsequent fiscal years from health care program reforms, consolidations, and streamlining.

(2) The annual savings report shall include a description of net savings factoring

in increased administrative expenses from the following:

(a) **Enrollment of medicaid clients in medicaid managed care programs.** In calculating savings from enrollment of medicaid clients into medicaid managed care programs, the department shall calculate the total annual savings from growth in managed care enrollment subsequent to June 30, 1997.

(b) **Consolidation of the children's portions of the Colorado indigent care program into the plan.** In calculating the savings accrued and anticipated from consolidation of the children's portions of the Colorado indigent care program, created in ~~article 15~~ PART 1 OF ARTICLE 3 of this title, into the plan, the department shall use the following methodology: Estimate the reduction in expenditures due to the reduction in the number of children under age nineteen served by the Colorado indigent care program for each fiscal year in which children have been enrolled in the children's basic health plan.

(3) As reported in the annual savings report, the total savings from consolidation of the children's portions of the Colorado indigent care program, created in ~~article 15~~ PART 1 OF ARTICLE 3 of this title, into the plan shall not reduce the reimbursement rate of expenditures made on behalf of children to the Colorado indigent care program enrolled providers below the reimbursement rates used in the fiscal year prior to the first child enrolling in the plan.

(4) The department shall modify total savings calculated in paragraph (b) of subsection (2) of this section according to the geographic residence of subsidized enrollees and to the probable location of their health care providers under the Colorado indigent care program, created in ~~article 15~~ PART 1 OF ARTICLE 3 of this title.

~~(5) Repeated.~~

25.5-8-107. [Formerly 26-19-107] Duties of the department - schedule of services - premiums - copayments - subsidies. (1) In addition to any other duties pursuant to this article, the department shall have the following duties:

(a) (I) To design, on or after April 21, 1998, and from time to time revise, a schedule of health care services included in the plan and to propose said schedule to the medical services board for approval or modification. The schedule of health care services as proposed by the department and approved by the medical services board shall include, but shall not be limited to, preventive care, physician services, prenatal care and postpartum care, inpatient and outpatient hospital services, prescription drugs and medications, and other services that may be medically necessary for the health of enrollees. The department shall design and revise this schedule of health care services included in the plan to be based upon the basic and standard health benefit plans defined in section 10-16-102 (4) and (42), C.R.S.; except that the department may modify the basic and the standard health benefit plans to meet specific federal requirements or to accommodate those changes necessary for a program designed specifically for children.

(II) In addition to the items specified in subparagraph (I) of this paragraph (a) and any additional items approved by the medical services board, on and after January

1, 2001, the medical services board shall include dental services in the schedule of health care services upon a finding by the board that:

(A) An adequate number of dentists are willing to provide services to eligible children; and

(B) The financial resources available to the program are sufficient to fund such services.

(b) To design and implement a system of cost-sharing with enrollees using an annual enrollment fee that is based on a sliding fee scale. The sliding fee scale shall be developed based on the enrollee's family income; except that no enrollment fee shall be assessed against an enrollee whose family income is at or below one hundred fifty percent of the federal poverty level and no enrollment fee shall be assessed against an enrollee who is a pregnant woman. As permitted by federal and state law, enrollees in the plan may use funds from a medical savings account to pay the annual enrollment fee. On or before November 1 of each year, the department shall submit for approval to the joint budget committee its annual proposal for cost sharing for the plan based upon a family's income.

(c) To design and implement a structure of copayments due to providers of managed health care plans from enrollees. Enrollees in the plan may use funds from a medical savings account to pay copayments.

(d) To design and propose to the medical services board for adoption detailed rules of eligibility and enrollment processes for the plan;

(e) To design a procedure whereby a financial sponsor may pay the annual enrollment fee or some portion thereof on behalf of a subsidized or nonsubsidized enrollee; except that the payment made on behalf of said enrollee shall not exceed the total enrollment fee due from the enrollee;

(f) To design a procedure whereby the plan may pay subsidies for eligible persons to purchase coverage under the plan or a comparable health insurance product;

(g) To establish criteria to allow a managed care plan, the department, or some other entity to verify eligibility pursuant to section ~~26-19-109~~ 25.5-8-109;

~~(h) (Deleted by amendment, L. 2001, p. 914, § 8, effective August 8, 2001.)~~

~~(i)~~ (h) To conduct pilot projects including, but not limited to, testing models of marketing, enrollment, eligibility determination, and premium structures, to be implemented where appropriate and as approved by the joint budget committee;

~~(j) Repealed.~~

(2) The department is authorized to institute a program for competitive bidding pursuant to section 24-103-202 or 24-103-203, C.R.S., for providing medical services on a managed care basis for children under this article. The department shall select more than one managed care contractor to serve counties in which there

are providers contracting with more than one managed care plan. In counties where there is only one operational managed care plan, the department may contract with that managed care plan to serve children enrolled in the plan. The department shall assure the utilization of essential community providers for the provision of services including eligibility determination, enrollment, and outreach when reasonable. The department shall contract with managed care organizations for the delivery of health services pursuant to this article. The department may contract with essential community providers for health care services in areas of the state that are not adequately served by managed care organizations.

(3) The department may contract for billing and premium collection functions for the children's basic health plan with vendors who provide billing and premium collection functions for other state insurance programs in order to consolidate billing and premium collection functions among multiple state programs. Such contracts may be entered into if the department determines that the scope of work provided by the vendor is similar to the work requirements for the children's basic health plan and that it would be more efficient and cost-effective to contract with the same vendor on multiple programs.

(4) Commencing with fiscal year 2001-02, the annual administrative costs for the children's basic health plan shall not exceed ten percent of the total annual program costs.

25.5-8-108. [Formerly 26-19-108] Financial management. (1) The department shall propose rules for approval by the medical services board to implement financial management of the plan. Pursuant to such rules, the department shall adjust benefit levels, eligibility guidelines, and any other measure to ensure that sufficient funds are present to implement the provisions of this article. The department shall develop and use quality assurance measures, such as the health employer data information set (HEDIS) reports regarding provider compensation, adapted to children's needs, to ensure that appropriate health care outcomes are met and to justify the continued use of taxpayer dollars for the plan. The department shall implement performance-based contracting based on such quality assurance measures.

(2) The department shall make a quarterly assessment of the expected expenditures for the plan for the remainder of the current biennium and for the following biennium. The estimated expenditures, including minimum reserve requirements shall be compared to an estimate of the revenues that will be deposited in the trust fund. Based on this comparison, the department shall make adjustments as necessary to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and the following biennium.

(3) The department may, in addition to any other measure it determines to be necessary, decrease subsidies for annual enrollment fees or limit enrollment in the plan to ensure that the trust retains sufficient funds pursuant to subsection (1) of this section.

(4) (a) Nothing in this article or any rules promulgated pursuant to the plan shall be interpreted to create a legal entitlement in any person to coverage under the plan. Enrollment in the plan shall be limited based upon annual appropriations made out

of the trust by the general assembly as described in section ~~26-19-105~~ 25.5-8-105 and any grants and donations. The general assembly shall annually establish maximum enrollment figures for subsidized children. Such enrollment caps shall not be exceeded by the department regardless of whether the funding comes from annual appropriations or grants and donations. When enrollment in the plan must be limited pursuant to this subsection (4), the department shall give priority to children who would qualify for medicaid as if there were no asset testing and to children with family incomes under one hundred thirty-three percent of the federal poverty level.

(b) The department shall report quarterly to the joint budget committee on any enrollment caps that have been instituted for the plan and the number of children who are on waiting lists.

25.5-8-109. [Formerly 26-19-109] Eligibility - children - pregnant women.

(1) To be eligible for a subsidy, a child must not have currently nor in the three months prior to application for the plan have been insured by a comparable health plan through an employer, with the employer contributing at least fifty percent of the premium cost. Children who have lost insurance coverage due to a change in or loss of employment shall not be subject to the waiting period.

(2) If one child from a family is enrolled in the plan, all children must be enrolled, unless the other children have alternative health insurance coverage.

(3) The department may establish procedures such that children with family incomes that exceed one hundred eighty-five percent of the federal poverty guidelines may enroll in the plan, but are not eligible for subsidies from the department.

(4) Children who are determined to be eligible for the plan shall remain eligible for twelve months subsequent to the last day of the month in which they were enrolled; except that a child shall no longer be eligible for the plan and shall be disenrolled from the plan if the department becomes aware of or is notified that any of the following has occurred:

(a) The child has moved out of the state;

(b) The child has been enrolled in the medicaid program; or

(c) The child has been enrolled in a commercial health insurance plan during the twelve-month period following enrollment in the plan under this article.

(5) (a) ~~(b)~~ A pregnant woman whose family income exceeds one hundred thirty-three percent of the federal poverty level but does not exceed one hundred eighty-five percent of the federal poverty level shall be presumptively eligible for the plan. Once determined eligible for the plan, a pregnant woman shall be considered to be continuously eligible throughout the pregnancy and for the sixty days following the pregnancy, even if the woman's eligibility would otherwise terminate during such period due to an increase in income. Upon birth, a child born to a woman eligible for the plan shall be eligible for the plan and shall be automatically enrolled in the plan in accordance with the eligibility requirements for

children specified in subsection (4) of this section.

~~(H) Repealed.~~

(b) (I) Under the plan, prenatal and postpartum primary health care providers shall implement policies regarding the integration of evidence-based tobacco use treatments into the regular health care delivery system, including, but not limited to:

- (A) Assessment of tobacco use and exposure to second-hand smoke;
- (B) Education on the dangers of tobacco use during pregnancy and postpartum;
- (C) Referrals to appropriate cessation services.

(II) Health care providers may coordinate the implementation of such policies with the tobacco education, prevention, and cessation programs established in section 25-3.5-804, C.R.S.

(c) The addition of coverage under the plan for pregnant women shall only be implemented if the department obtains a waiver from the federal department of health and human services.

(d) Enrollment of a pregnant woman in the plan shall be limited based upon annual appropriations made out of the trust by the general assembly as described in section ~~26-19-105~~ 25.5-8-105 and any grants and donations. The general assembly shall annually establish maximum enrollment figures for pregnant women in the plan. The department shall not exceed the enrollment caps regardless of whether the funding comes from annual appropriations or grants and donations.

~~(6) Repealed.~~

25.5-8-110. [Formerly 26-19-110] Participation by managed care plans.

(1) Managed care plans, as defined in section 10-16-102 (26.5), C.R.S., that participate in the plan shall do so by contract with the department and shall provide the health care services covered by the plan to each enrollee.

(2) Managed care plans participating in the plan shall not discriminate against any potential or current enrollee based upon health status, sex, race, ethnicity, or religion.

(3) Managed care plans that contract with the department to provide the plan to enrollees shall also be willing to contract with the medicaid managed care program, as administered by the department.

~~(3.5)~~ (4) (a) Managed care plans shall be selected by the department to participate in the children's basic health plan based upon the managed care plans' assurances and the department's verification that the managed care plan is utilizing within its network essential community providers to the extent that this action does not result in a net increase in the cost for providing services to the managed care plan.

(b) The managed care organization shall seek proposals from each essential

community provider in a county in which the managed care organization is enrolling recipients for those services that the managed care organization provides or intends to provide and that an essential community provider provides or is capable of providing. To assist managed care organizations in seeking proposals, the ~~state~~ department shall provide managed care organizations with a list of essential community providers in each county. The managed care organization shall consider such proposals in good faith and shall, when deemed reasonable by the managed care organization based on the needs of its enrollees, contract with essential community providers. Each essential community provider shall be willing to negotiate on reasonably equitable terms with each managed care organization. Essential community providers making proposals under this subsection ~~(3.5)~~ (4) shall be able to meet the contractual requirements of the managed care organization. The requirement of this subsection ~~(3.5)~~ (4) shall not apply to a managed care organization in areas in which the managed care organization operates entirely as a group model health maintenance organization.

(c) Any disputes between a managed care organization and an essential community provider that cannot be resolved through good faith negotiations may be resolved through an informal review by the ~~state~~ department at the request of one of the parties, or through the ~~state~~ department's aggrieved provider appeal process in accordance with section 25.5-1-107 (2), C.R.S., if requested by one of the parties.

(d) In selecting managed care organizations through competitive bidding, the ~~state~~ department shall give preference to those managed care organizations that have executed contracts for services with one or more essential community providers. In selecting managed care organizations, the ~~state~~ department shall not penalize a managed care organization for paying cost-based reimbursement to federally qualified health centers as defined in the FEDERAL "Social Security Act".

~~(4)~~ (5) The department may receive and act upon complaints from enrollees regarding failure to provide covered services or efforts to obtain payment, other than authorized copayments, for covered services directly from eligible recipients.

~~(5)~~ (6) Parents or guardians of children shall choose a participating health maintenance organization before enrolling in the plan in areas of the state where a participating health maintenance organization is available. The department will assign children who are currently enrolled in the plan and whose parents or guardians have not selected a health maintenance organization within a time period determined by the department to a participating health maintenance organization with the child's primary care physician in the network. The department shall seek to maintain continuity of the health plan between medicaid and the children's basic health plan.

~~(5.5)~~ (7) In areas of the state in which a participating managed care plan does not have providers, the department may contract with essential community providers and other health care providers to provide health care services under the children's basic health plan using a managed care model.

~~(5.6)~~ (8) The department may contract with essential community providers or other providers or develop other administrative arrangements to provide health care services under the children's basic health plan to enrollees prior to the effective date

of enrollment in the selected managed care plan.

~~(6)~~ (9) The department shall allow, at least annually, an opportunity for enrollees to transfer among participating managed care plans serving their respective geographic regions. The department shall establish a period of at least twenty days annually when this opportunity is afforded eligible recipients. In geographic regions served by more than one participating managed care plan, the department shall endeavor to establish a uniform period for such opportunity.

~~(7)~~ (10) The department shall make a capitation payment to managed care plans based upon a defined scope of services at an agreed upon rate. The department shall only use market rate bids that do not discriminate and are adequate to assure quality, network sufficiency, and long-term competitiveness in the children's basic health plan managed care market. The department shall retain a qualified actuary to establish a lower limit for such bids. A certification by such actuary to the appropriate lower limit shall be conclusive evidence of the department's compliance with the requirements of this subsection ~~(7)~~ (10). For the purposes of this subsection ~~(7)~~ (10), a "qualified actuary" shall be a person deemed as such under ~~regulations~~ RULES promulgated by the commissioner of insurance.

~~(8)~~ (11) All managed care plans participating in the plan shall meet standards regarding the quality of services to be provided, financial integrity, and responsiveness to the unmet health care needs of eligible persons that may be served.

25.5-8-111. [Formerly 26-19-111] Department - administration - outsourcing.

~~(1) (Deleted by amendment, L. 2001, p. 550, § 6, effective August 8, 2001.)~~

~~(2)~~ (1) (a) The department may:

(I) Pursuant to section 24-50-504 (2) (a), C.R.S., enter into personal services contracts for the administration of the children's basic health plan. Any contracts established pursuant to this section shall contain performance measures that shall be monitored by the department.

(II) Use county departments of social services to perform functions relating to the administration of the children's basic health plan;

(III) Perform administrative functions at the department, including consolidation of functions with other administrative functions handled by the department.

(b) In deciding how to allocate functions relating to the administration of the children's basic health plan as allowed under paragraph (a) of this subsection ~~(2)~~ (1), the department shall determine and base its decisions upon what is the most cost-effective method to handle the particular function and to deliver the services.

~~(3)~~ (2) The implementation of subparagraph (I) of paragraph (a) of subsection ~~(2)~~ (1) of this section is contingent upon a finding by the state personnel director that any of the conditions of section 24-50-504 (2), C.R.S., have been met or that the

conditions of section 24-50-503 (1), C.R.S., have been met.

25.5-8-112. [Formerly 26-19-112] Authority to the department to apply for federal waivers. The department is hereby authorized and required to apply for any federal waivers necessary to implement the purposes of this article.

25.5-8-113. [Formerly 26-19-113] Reports by contractors to medical services board. Any personal services contractor that contracts with the ~~state~~ department to provide services under this article shall provide quarterly reports to the medical services board relating to the functions performed by the contractor, including reports on enrollment, utilization, marketing, and any concerns or recommendations relating to improving the administration of or the quality of the program. In addition, any contractor shall submit any data requested by the medical services board relating to the children's basic health plan and the functions provided by that contractor.

SECTION 8. 26-1-103 (4), (5), (6), and (7), Colorado Revised Statutes, are amended to read:

26-1-103. Definitions. As used in this title, unless the context otherwise requires:

(4) "Executive director" means the executive director of the department of human services. ~~except that "executive director" for the purposes of articles 4 and 15 of this title and in connection with the adult foster care program, the home care allowance program, the treatment program for high-risk pregnant women, the old age pension health and medical care program, and the supplemental old age pension health and medical care program means the executive director of the department of health care policy and financing.~~

(5) "State board" means the state board of human services authorized to act in accordance with the provisions of section 26-1-107. ~~except that "state board" or "board" for the purposes of articles 4 and 15 of this title and in connection with the adult foster care program, the home care allowance program, the old age pension health and medical care program, and the supplemental old age pension health and medical care program means the medical services board established in part 3 of article 1 of title 25.5, C.R.S.~~

(6) "State department" means the department of human services. ~~except that "state department" for the purposes of articles 4 and 15 of this title and in connection with the adult foster care program, the home care allowance program, the treatment program for high-risk pregnant women, the old age pension health and medical care program, and the supplemental old age pension health and medical care program means the department of health care policy and financing.~~

(7) "State designated agency" means an agency designated to perform specified functions that would otherwise be performed by the county departments. ~~including the single entry point agencies established pursuant to part 5 of article 4 of this title.~~

SECTION 9. 26-1-104, Colorado Revised Statutes, is amended to read:

26-1-104. Construction of terms. (1) Whenever any law of this state refers to the state department of public welfare or the state department of social services, or to the director, ~~of either department~~, said law shall be construed as referring to the department of human services or to the executive director of the department of human services. ~~as the case may be, except that said references in connection with any provision of law concerning the "Colorado Medical Assistance Act", health care for the medically indigent, adult foster care, home care allowance, or the treatment program for high-risk pregnant women shall be construed as referring to the department of health care policy and financing or to the executive director of the department of health care policy and financing.~~ Whenever any law of this state refers to the division of public assistance, or to the division of children and youth, or to any other division of the state department, said law shall be construed as referring to the department of human services.

(2) Whenever any law of this state refers to the state board of public welfare or to the state board of social services, said law shall be construed as referring to the state board of human services. ~~except that said references in connection with any provision of law concerning the "Colorado Medical Assistance Act", health care for the medically indigent, adult foster care, home care allowance, or the treatment program for high-risk pregnant women shall be construed as referring to the medical services board or the executive director of the department of health care policy and financing, whichever is appropriate.~~

SECTION 10. 26-1-107 (6) (g), (7), (9), and (9.5), Colorado Revised Statutes, are amended to read:

26-1-107. State board of human services. (6) The state board shall:

(g) Adopt rules concerning mental health programs, alcohol and drug abuse programs, and developmental disabilities programs. TO THE EXTENT THAT RULES ARE PROMULGATED BY THE STATE BOARD OF HUMAN SERVICES FOR PROGRAMS OR PROVIDERS THAT RECEIVE EITHER MEDICAID ONLY OR BOTH MEDICAID AND NON-MEDICAID FUNDING, THE RULES SHALL BE DEVELOPED IN COOPERATION WITH THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND SHALL NOT CONFLICT WITH STATE STATUTES OR FEDERAL STATUTES OR REGULATIONS.

(7) When federal statute or regulation requires, as a condition for the receipt of federal participation in any state department administered or supervised public assistance or welfare program, that specific forms of income to recipients and applicants or other persons whose income would otherwise be considered TO be disregarded, such income shall be disregarded and the rules of the state board shall include provisions to effect such requirements.

(9) ~~On and after July 1, 1994, the state board shall have no authority over the "Colorado Medical Assistance Act", the "Reform Act for the Provision of Health Care for the Medically Indigent", the adult foster care program, the home care allowance program, or the treatment program for high-risk pregnant women. Any reference to the state board in connection with said programs shall be deemed to refer to the medical services board or the executive director of the department of health care policy and financing, whichever is appropriate.~~

(9.5) ~~On and after July 1, 2003, any reference to the state board in connection with the old age pension health and medical care program, the supplemental old age pension health and medical care program, the old age pension health and medical care fund, and the supplemental old age pension health and medical care fund shall be deemed to refer to the medical services board or the executive director of the department of health care policy and financing, whichever is appropriate.~~

SECTION 11. 26-1-109 (1) and (2) (a), Colorado Revised Statutes, are amended to read:

26-1-109. Cooperation with federal government - grants-in-aid. (1) The state department of human services shall be the sole state agency for administering the state plans for public assistance and welfare, including but not limited to assistance payments; food stamps; social services; ~~health and medical assistance other than the home care allowance program, the adult foster care program, and programs established pursuant to the "Colorado Medical Assistance Act" set forth in article 4 of this title;~~ child welfare services; rehabilitation; and programs for the aging in cooperation with the federal government; the Colorado works program; and any other state plan relating to such public assistance and welfare that requires state action that is not specifically the responsibility of some other state department, division, section, board, commission, or committee under the provisions of federal or state law.

(2) (a) The state department of human services may accept on behalf of the state of Colorado the provisions and benefits of acts of congress designed to provide funds or other property for particular public assistance and welfare activities within the state, including but not limited to assistance payments; food stamps; social services; ~~medical assistance other than the home care allowance program, the adult foster care program, and programs established pursuant to the "Colorado Medical Assistance Act" set forth in article 4 of this title;~~ child welfare services; rehabilitation; and programs for the aging; which funds or other property are designated for such purposes within the function of the state department, and may accept on behalf of the state any offers which have been or may from time to time be made of funds or other property by any persons, agencies, or entities for particular public assistance and welfare activities within the state, which funds or other property are designated for such purposes within the function of the state department; but, unless otherwise expressly provided by law, such acceptance shall not be manifested unless and until the state department has recommended such acceptance to and received the written approval of the governor and the attorney general. Such approval shall authorize the acceptance of the funds or property in accordance with the restrictions and conditions and for the purpose for which funds or property are intended.

SECTION 12. Repeal. 26-1-111 (6), Colorado Revised Statutes, is repealed as follows:

26-1-111. Activities of the state department under the supervision of the executive director - study - cash fund. (6) ~~The state department shall cooperate with the department of health care policy and financing in administering the delivery of medical assistance by county departments of social services or any other public or private entities participating in the delivery of medical assistance pursuant to~~

~~article 4 of this title.~~

SECTION 13. 26-1-112 (1), (2), and (3) (b), Colorado Revised Statutes, are amended to read:

26-1-112. Locating violators - recoveries. (1) The executive director of the department of human services ~~the executive director of the department of health care policy and financing~~, or district attorneys may request and shall receive from departments, boards, bureaus, or other agencies of the state or any of its political subdivisions, and the same are authorized to provide, such assistance and data as will enable the state department of human services ~~the state department of health care policy and financing~~, and county departments properly to carry out their powers and duties to locate and prosecute any person who has fraudulently obtained public assistance ~~or medical assistance~~ under this title. Any records established pursuant to the provisions of this section shall be available only to the state department of human services ~~the state department of health care policy and financing~~, the county departments, the attorney general, and the district attorneys, county attorneys, and courts having jurisdiction in fraud or recovery proceedings or actions.

(2) (a) All departments and agencies of the state and local governments shall cooperate in the location and prosecution of any person who has fraudulently obtained public assistance ~~or medical assistance~~ under this title, and, on request of the county board, the county director, the state department of human services ~~the state department of health care policy and financing~~, or the district attorney of any judicial district in this state, shall supply all information on hand relative to the location, employment, income, and property of such persons, notwithstanding any other provision of law making such information confidential, except the laws pertaining to confidentiality of any tax returns filed pursuant to law with the department of revenue. The department of revenue shall furnish at no cost to inquiring departments and agencies such information as may be necessary to effectuate the purposes of this article. The procedures whereby this information will be requested and provided shall be established by ~~regulation~~ RULE of the ~~appropriate~~ state department. The state ~~departments~~ DEPARTMENT or county departments shall use such information only for the purposes of administering public assistance ~~or medical assistance~~ under this title, and the district attorney shall use it only for the prosecution of persons who have fraudulently obtained public assistance ~~or medical assistance~~ under this title, and he shall not use the information, or disclose it, for any other purpose.

(b) (I) Whenever the state department of human services ~~the state department of health care policy and financing~~, or a district attorney, for ~~either~~ THE state department, or the state ~~departments~~ DEPARTMENT on behalf of a county department ~~recover~~ RECOVERS any amount of fraudulently obtained public assistance ~~or medical assistance~~ funds, the federal government shall be entitled to a share proportionate to the amount of federal funds paid unless a different amount is otherwise provided by federal law, the state shall be entitled to a share proportionate to the amount of state funds paid and such additional amounts of federal funds recovered as provided by federal law, and the county department shall be entitled to a share proportionate to the amount of county funds paid unless a different amount is provided pursuant to federal law or this section.

(II) Whenever a county department, a county board, a district attorney, or a state department on behalf of a county department recovers any amount of fraudulently obtained public assistance funds in the form of assistance payments, ~~or medical assistance~~ it shall be deposited in the county general fund and the federal government shall be entitled to a share proportionate to the amount of federal funds paid unless a different amount is provided for by federal law, the state shall be entitled to a share proportionate to one-half the amount of state funds paid, and the county shall be entitled to a share proportionate to the amount of county funds paid and, in addition, a share proportionate to one-half the amount of state funds paid. In the case of funds recovered from fraudulently obtained food stamp coupons by the county department, the county board, the district attorney, or ~~a~~ THE state department on behalf of a county department, the county shall be entitled to the share of the recovered funds provided by the federal "Food Stamp Act".

(3) (b) Whenever a county department, a county board, a district attorney, or ~~a~~ THE state department on behalf of the county recovers any amount of public assistance payments ~~or medical assistance~~ funds that were obtained through unintentional client error, the federal government shall be entitled to a share proportionate to the amount of federal funds paid, unless a different amount is provided for by federal law, the state shall be entitled to a share proportionate to seventy-five percent of the amount of state funds paid, the county shall be entitled, except for the Colorado works program, to a share proportionate to the amount of county funds paid, if any, and, in addition, a share proportionate to twenty-five percent of the amount of state funds paid. In the Colorado works program, the county shall be entitled to a share proportionate to the amount of county funds paid and, in addition, a share proportionate to one-half the amount of state funds paid.

SECTION 14. 26-1-114 (1), (3) (c), and (3) (d), Colorado Revised Statutes, are amended to read:

26-1-114. Records confidential - authorization to obtain records of assets - release of location information to law enforcement agencies - outstanding felony arrest warrants. (1) The state department of human services ~~and the state department of health care policy and financing~~ may establish reasonable rules ~~and regulations~~ to provide safeguards restricting the use or disclosure of information concerning applicants, recipients, and former and potential recipients of federally aided public assistance and welfare, including but not limited to assistance payments, food stamps, social services, ~~medical assistance~~, and child welfare services, to purposes directly connected with the administration of such public assistance and welfare and related state department activities and covering the custody, use, and preservation of the records, papers, files, and communications of the state and county departments. Whenever, under provisions of law, names and addresses of applicants for, recipients of, or former and potential recipients of public assistance and welfare are furnished to or held by another agency or department of government, such agency or department shall be required to prevent the publication of lists thereof and their uses for purposes not directly connected with the administration of such public assistance and welfare.

(3) (c) (I) In order to determine if applicants for or recipients of public ~~or medical assistance~~ have assets within eligibility limits, the state department of human services ~~or the state department of health care policy and financing~~ may provide a

list of information identifying these applicants or recipients to any financial institution, as defined in section 15-15-201 (4), C.R.S., or to any insurance company. This information may include identification numbers or social security numbers. The state department of human services ~~or the state department of health care policy and financing~~ may require any such financial institution or insurance company to provide a written statement disclosing any assets held on behalf of individuals adequately identified on the list provided. Before a termination notice is sent to the recipient, the county department in verifying the accuracy of the information obtained as a result of the match shall contact the recipient and inform him or her of the apparent results of the computer match and give the recipient the opportunity to explain or correct any erroneous information secured by the match. The requirement to run a computerized match shall apply only to information that is entered in the financial institution's or insurance company's data processing system on the date the match is run and shall not be deemed to require any such institution or company to change its data or make new entries for the purpose of comparing identifying information. The cost of providing such computerized match shall be borne by the appropriate state department. The state department of human services shall not use the provisions of this subparagraph (I) for the information-gathering purposes of the financial institution data match system required by section 26-13-128.

(II) For the fiscal year beginning July 1, 1984, and thereafter, all funds expended by the state department to pay the cost of providing such computerized matches shall be subject to an annual appropriation by the general assembly.

(III) The state department of human services ~~or the state department of health care policy and financing~~ may expend funds appropriated pursuant to subparagraph (II) of this paragraph (c) in an amount not to exceed the amount of annualized general fund savings that result from the termination of recipients from public ~~or medical~~ assistance specifically due to disclosure of assets pursuant to this subsection (3).

(IV) The state department of human services ~~and the state department of health care policy and financing~~ shall make quarterly reports concerning the value of computerized matches pursuant to this paragraph (c) to the general assembly and the joint budget committee. Such reports shall include, but need not be limited to, the number of individuals against whom computer matches were run, the number of resulting matches, and the resulting public ~~or medical~~ assistance case load reduction and corresponding savings to the ~~respective~~ state department.

(d) No applicant shall be denied nor any recipient discontinued due to the disclosure of their assets unless and until the county department has assured that such assets taken together with other assets exceed the limit for eligibility of countable assets. Any information concerning assets found may be used to determine if such applicant's or recipient's eligibility for other public assistance ~~or medical assistance~~ is affected.

SECTION 15. 26-1-115 (1) and (3), Colorado Revised Statutes, are amended to read:

26-1-115. County departments - district departments. (1) Except as provided

in subsections (2) ~~and (3)~~ of this section, there shall be established in each county of the state a county department of social services which shall consist of a county board of social services, a county director of social services, and such additional employees as may be necessary for the efficient performance of public assistance and welfare activities, including but not limited to assistance payments, food stamps, and social services.

~~(3) Single entry point agencies established pursuant to part 5 of article 4 of this title, other than county departments acting as single entry point agencies, may act as state designated agencies and are hereby authorized to carry out functions as specified in part 5 of article 4 of this title that are otherwise performed by county departments.~~

SECTION 16. 26-1-119, Colorado Revised Statutes, is amended to read:

26-1-119. County staff. The county director, with the approval of the county board, shall appoint such staff as may be necessary as determined by the ~~appropriate~~ state department rules to administer public assistance and welfare ~~medical assistance~~, and child welfare activities within his or her county. Such staff shall be appointed and shall serve in accordance with a merit system for the selection, retention, and promotion of county department employees as described in section 26-1-120. The salaries of the members of such staff shall be fixed in accordance with the rules and salary schedules prescribed by the ~~appropriate~~ state department; except that, once a county transfers its county employees to a successor merit system as provided in section 26-1-120, the salaries shall be fixed by the county commissioners.

SECTION 17. 26-1-121 (1) (a), (1) (b), and (3), Colorado Revised Statutes, are amended to read:

26-1-121. Appropriations - food distribution programs. (1) (a) For carrying out the duties and obligations of the state department of human services ~~the state department of health care policy and financing~~, and county departments under the provisions of this title and for matching such federal funds or meeting maintenance of effort requirements as may be available for public assistance and welfare activities in the state, including but not limited to assistance payments, food stamps (except the value of food stamp coupons), social services, ~~medical assistance~~, child welfare services, rehabilitation, programs for the aging and for veterans, and related activities, the general assembly, in accordance with the constitution and laws of the state of Colorado, shall make adequate appropriations for the payment of such costs, pursuant to the budget prepared by the ~~respective~~ executive director.

(b) Subject to the provisions of section 26-1-109 (2), if the federal law shall provide federal funds, in cash or in another form such as food stamps, for public assistance and welfare activities, including but not limited to assistance payments, food stamps, social services, ~~medical assistance~~, and child welfare services, not otherwise provided for in this title, the ~~appropriate~~ state department is authorized to make such payments or offer such services in accordance with the requirements accompanying said federal funds within the limits of available state appropriations.

(3) The expenses of training personnel for special skills relating to public

assistance and welfare activities, including but not limited to assistance payments, food stamps, social services, ~~medical assistance~~, child welfare services, rehabilitation, and programs for the aging, as such expenses shall be determined and approved by the ~~appropriate~~ state department, may be paid from whatever state and federal funds are available for such training purposes.

SECTION 18. 26-1-122.5 (1) and (6), Colorado Revised Statutes, are amended to read:

26-1-122.5. County appropriation increases - limitations. (1) Beginning in calendar fiscal year 1994 and for each calendar fiscal year thereafter to and including calendar fiscal year 1997, the board of county commissioners in each county of this state shall annually appropriate funds for the county share of the administrative costs and program costs of public assistance ~~medical assistance~~, and food stamps in the county in an amount equal to the actual county share for the previous fiscal year adjusted by an amount equal to the actual county share for the previous fiscal year multiplied by the percentage of change in property tax revenue.

(6) The limitation set forth in this section on the increase in the county share of the administrative costs and program costs of public assistance ~~medical assistance~~, and food stamps will result in increased costs to the state. By making state funds available, the state is encouraging counties not to exercise any right a county may have pursuant to section 20 (9) of article X of the Colorado constitution to reduce or end its share of the costs of public assistance ~~medical assistance~~, and food stamps for the county for three fiscal years following the fiscal year in which the state funds are received. If a county accepts funds from the state based on the limitation provided in this section for any fiscal year, the county agrees not to exercise any rights the county may have to reduce or end its share of the costs of public assistance ~~medical assistance~~, and food stamps for the fiscal year in which the funds are accepted. Nothing in this subsection (6) or any agreement pursuant to this subsection (6) shall be construed to affect the existence or status of any rights accruing to the state or any county pursuant to section 20 (9) of article X of the Colorado constitution.

SECTION 19. 26-1-132 (1), (3), and (4), Colorado Revised Statutes, are amended to read:

26-1-132. Department of human services - rate setting - residential treatment service providers - monitoring and auditing - report. (1) The state department shall develop a rate-setting process consistent with medicaid requirements for providers of residential treatment services in the state of Colorado. Representatives of counties and the provider community shall be involved in the actual development of the rate-setting process. THE RATE-SETTING PROCESS FOR RATES FUNDED BY MEDICAID SHALL BE APPROVED BY THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING. The rate-setting process developed pursuant to this section may include, but shall not be limited to:

(a) A range for reimbursement that represents a base-treatment rate for serving a child who is subject to out-of-home placement due to dependency and neglect, a child placed in a residential child care facility pursuant to the "Child Mental Health Treatment Act", article 10.3 of title 27, C.R.S., or a child who has been adjudicated

a delinquent, which includes a defined service package and does not link the rate to the child's evaluation or assessment;

(b) A request for proposal to contract for specialized service needs of a child, including but not limited to: Substance-abuse treatment services; sex offender services; and services for the developmentally disabled; and

(c) Negotiated incentives for achieving outcomes for the child as defined by the state department, counties, and providers.

(3) The rate-setting process developed by the state department, counties, and providers AND APPROVED BY THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING pursuant to subsection (1) of this section shall include recommendations for a two- or three-year implementation timeline with implementation beginning in state fiscal year 2007-08.

(4)(a) The state department, in conjunction with the counties and providers, shall submit an initial report to the joint budget committee of the general assembly on or before July 1, 2006. The report shall include the rate-setting process and the recommended implementation timeline developed pursuant to this section.

(b) ~~The state department, representatives of the counties, and the provider community shall review the rate-setting process every two years and shall submit any recommended changes to the joint budget committee of the general assembly.~~ THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND THE STATE DEPARTMENT, IN CONSULTATION WITH THE REPRESENTATIVES OF THE COUNTIES AND THE PROVIDER COMMUNITY, SHALL REVIEW THE RATE-SETTING PROCESS EVERY TWO YEARS AND SHALL SUBMIT ANY RECOMMENDED CHANGES TO THE JOINT BUDGET COMMITTEE OF THE GENERAL ASSEMBLY.

SECTION 20. Part 1 of article 1 of title 26, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

26-1-134. Home- and community-based services for persons with developmental disabilities - cooperation. IT IS THE INTENT OF THE GENERAL ASSEMBLY THAT THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING AND THE STATE DEPARTMENT COOPERATE TO THE MAXIMUM EXTENT POSSIBLE IN DESIGNING, IMPLEMENTING, AND ADMINISTERING THE PROGRAM AUTHORIZED UNDER PART 4 OF ARTICLE 6 OF TITLE 25.5, C.R.S.

SECTION 21. 26-1-201 (1) (d), Colorado Revised Statutes, is amended to read:

26-1-201. Programs administered - services provided - department of human services. (1) This section specifies the programs to be administered and the services to be provided by the department of human services. These programs and services include the following:

(d) Public assistance programs, as specified in article 2 of this title; ~~except that adult foster care and home care allowance and the treatment program for high-risk pregnant women shall be administered by the department of health care policy and financing;~~

SECTION 22. 26-2-114 (2) (a), Colorado Revised Statutes, is amended to read:

26-2-114. Amount of assistance payments - old age pension. (2) (a) (I) The ~~medical services~~ STATE board in the department of ~~health care policy and financing~~ HUMAN SERVICES, with the consent of the general assembly and subject to available funds, may provide adult foster care for persons eligible to receive old age pension. For the purposes of this subparagraph (I), "adult foster care" means the care and services defined in section 26-2-122.3.

(II) (A) The ~~medical services~~ STATE board in the department of ~~health care policy and financing~~ HUMAN SERVICES, with the consent of the general assembly and subject to available funds, may provide a home care allowance for persons eligible to receive old age pensions. For the purposes of this subparagraph (II), "home care allowance" means care and services defined in section 26-2-122.3.

(B) Repealed.

SECTION 23. Repeal of provisions being relocated in this act. 26-2-117 and 26-2-119.5, Colorado Revised Statutes, are repealed.

SECTION 24. 26-2-122.3, Colorado Revised Statutes, is amended to read:

26-2-122.3. Adult foster care and home care allowance as services under certain public assistance programs - administered by department of human services - repeal. (1) (a) (I) In addition to the amount of assistance available pursuant to the provisions of this article, the ~~medical services~~ STATE board in the STATE department, ~~of health care policy and financing~~, with the consent of the general assembly and subject to available funds, may provide adult foster care for persons eligible to receive old age pension, aid to the needy disabled, or aid to the blind. For purposes of this paragraph (a), "adult foster care" means that care and service which, in addition to room and board, may include, but is not limited to, personal services, recreational opportunities, transportation, utilization of volunteer services, and special diets. Such care is provided to recipients of federal supplemental security income benefits who are also eligible for the Colorado supplement program for aid to the needy disabled or aid to the blind and who do not require skilled nursing care or intermediate health care and cannot remain in or return to their residences but who need to reside in a supervised nonmedical setting on a twenty-four-hour basis. Those persons with developmental disabilities as defined in section 27-10.5-102, C.R.S., or who are receiving or eligible to receive services pursuant to any provision of title 27, C.R.S., do not qualify for adult foster care under this paragraph (a).

(II) Adult foster care facilities shall be certified by the single entry point agency in the single entry point district in which they are located; except that each county department of social services shall certify adult foster care facilities located in such county until a single entry point agency has been established pursuant to section ~~26-4-522~~ 25.5-6-106, C.R.S.

(b) In addition to the amount of assistance available pursuant to paragraph (a) of this subsection (1), the ~~medical services~~ STATE board in the STATE department, ~~of health care policy and financing~~, with the consent of the general assembly and

subject to available funds, may provide a home care allowance for persons eligible to receive old age pension, aid to the needy disabled, or aid to the blind. For the purposes of this paragraph (b), "home care allowance" is a program that provides payments, subject to available appropriations, to functionally impaired persons who are, or who would be but for their income, eligible to receive old age pension pursuant to section 26-2-114, aid to the needy disabled pursuant to section 26-2-119, or aid to the blind pursuant to section 26-2-120. To be eligible for a home care allowance, a person's monthly gross income shall be less than the applicable monthly grant standard for the old age pension, aid to the needy disabled, or aid to the blind programs, plus the person's authorized monthly home care allowance grant, as determined in accordance with rules promulgated pursuant to this paragraph (b). The home care allowance grant shall not exceed the equivalent of four hundred twenty-nine service units per year for a member of the eligible person's family. The payments allow recipients who are in need of long-term care to purchase community-based services as defined in section ~~26-4-507 (2) (c)~~ 25.5-6-104 (2) (c), C.R.S. Such services may include, but need not be limited to, the supervision of self-administered medications, assistance with activities of daily living as defined in section ~~26-4-507 (2) (a)~~ 25.5-6-104 (2) (a), C.R.S., and assistance with instrumental activities of daily living as defined in section ~~26-4-507 (2) (g)~~ 25.5-6-104 (2) (g), C.R.S. The rules adopted by the ~~medical services~~ STATE board shall specify, in accordance with the provisions of this section, the services available under the program and shall specify eligibility criteria for the home care allowance program, which shall be in addition to the eligibility criteria for the old age pension, aid to the needy disabled, or aid to the blind programs. In addition, the rules shall specifically provide for a determination as to the person's functional impairment and the person's unmet need for paid care and shall address amounts awarded to persons eligible for home care allowance. The ~~medical services~~ STATE board shall specify in the rules the methods for determining the unmet need for paid care and the amount of a home care allowance that may be awarded to eligible persons. The amount of the home care allowance shall not exceed the equivalent of four hundred twenty-nine service units per year for a member of the eligible person's family. Such methods may be based on how often a person experiences unmet need for paid care or any other method that the ~~medical services~~ STATE board determines is valid in correlating unmet need for paid care with an amount of a home care allowance award. The ~~medical services~~ STATE board shall require that eligibility and unmet need for paid care be determined through the use of a comprehensive and uniform client assessment instrument as described in section ~~26-4-507~~ 25.5-6-104, C.R.S. The ~~medical services~~ STATE board may adjust income eligibility criteria, including any functional impairment standard, or the amounts awarded to eligible persons or may limit or suspend enrollments as necessary to manage the home care allowance program within the funds appropriated by the general assembly. In addition, the ~~medical services~~ STATE board may adjust which services are available under the program; except that such adjustment shall be consistent with the provisions of this subsection (1).

(c) The STATE department of ~~health care policy and financing~~ is authorized to implement pilot programs that it deems feasible to assess the overall impact, if any, of using alternatives to the method described in paragraph (b) of this subsection (1) for determining eligible person's unmet need for paid care and the amount of a home care allowance awarded to an eligible person. ~~If necessary for the implementation of this paragraph (c), the department shall seek waivers from the federal government~~

~~in connection with any programs related to the home care allowance program.~~

(2) ~~The STATE department of health care policy and financing shall administer the adult foster care program and the home care allowance program. The executive director or the medical services STATE board, as appropriate, shall promulgate rules necessary for the implementation of this section.~~

(3) THE RULES OF THE MEDICAL SERVICES BOARD PERTAINING TO HOME CARE ALLOWANCE AND ADULT FOSTER CARE SHALL BE IN EFFECT UNTIL AMENDED, MODIFIED, OR REPEALED BY THE STATE BOARD OF HUMAN SERVICES.

(4) (a) THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING SHALL ASSIST IN THE PROCESS OF TRANSITIONING THE HOME CARE ALLOWANCE AND ADULT FOSTER CARE PROGRAMS TO THE STATE DEPARTMENT. THE TRANSITION SHALL INCLUDE TRAINING AND THE TRANSFER OF MATERIALS AND INFORMATION.

(b) THIS SUBSECTION (4) IS REPEALED, EFFECTIVE JULY 1, 2007.

(5) THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING SHALL CONTINUE TO CONTRACT WITH THE SINGLE ENTRY POINT AGENCIES FOR THE FINANCING, ASSESSMENT, AND CASE MANAGEMENT FUNCTIONS OF THE HOME CARE ALLOWANCE AND ADULT FOSTER CARE PROGRAMS.

SECTION 25. 26-2-136 (2) and (3), Colorado Revised Statutes, are amended to read:

26-2-136. Personal identification systems for public assistance and medical assistance - committee to select methods. (2) The personal identification committee shall study and recommend what security measures, such as individual personal identification numbers, photo identification, fingerprint identification, or retinal scanning, should be used to identify applicants for purposes of determining whether a person applying for public assistance ~~or medical assistance~~ is eligible to receive such benefits. In making such recommendations, the committee shall consider the extent of the security problem, the cost of possible security measures, which measures, if any, will be most cost-effective, and which will be the most successful at preventing and detecting fraud and duplicate participation.

(3) In addition to the security measures selected pursuant to subsection (2) of this section, the state department ~~and the department of health care policy and financing~~ shall use social security numbers to the extent ~~possible~~ ALLOWABLE UNDER FEDERAL LAW as a method of personal identification for every person applying for public assistance. ~~or medical assistance.~~

SECTION 26. 26-2-103 (11), Colorado Revised Statutes, is amended to read:

26-2-103. Definitions. As used in this article AND ARTICLE 1 OF THIS TITLE, unless the context otherwise requires:

(11) (a) "Social services" means services and payments for services ~~(other than medical services covered by the "Colorado Medical Assistance Act" or the old age pension health and medical care program or the supplemental old age pension health~~

~~and medical care program~~) available, directly or indirectly, through the staff of the state department of human services and county departments of social services or through state designated agencies, where applicable, for the benefit of eligible persons, which services are provided pursuant to rules ~~and regulations~~ adopted by the state ~~department~~ BOARD. "Social services" may include but need not be limited to day care, homemaker services, foster care, and other services to individuals or families for the purpose of attaining or retaining capabilities for maximum self-care, self-support, and personal independence and services to families or members of families for the purpose of preserving, rehabilitating, reuniting, or strengthening the family. At such time as Title XX of the social security act becomes effective with respect to federal reimbursements, "social services" may include but need not be limited to child care services, protective services for children and adults, services for children and adults in foster care, services related to the management and maintenance of the home, day care services for adults, transportation services, training and related services, employment services, information, referral, and counseling services, the preparation and delivery of meals, health support services, and appropriate combinations of services designed to meet the special needs of children, the aged, the mentally retarded, the blind, the emotionally disturbed, persons with physical disabilities, and alcoholics and drug addicts.

(b) "SOCIAL SERVICES" DOES NOT INCLUDE MEDICAID SERVICES UNLESS THOSE SERVICES ARE DELEGATED TO THE STATE DEPARTMENT. "SOCIAL SERVICES" DOES NOT INCLUDE MEDICAL SERVICES COVERED BY THE OLD AGE PENSION HEALTH AND MEDICAL CARE PROGRAM, THE SUPPLEMENTAL OLD AGE PENSION HEALTH AND MEDICAL CARE PROGRAM, THE CHILDREN'S BASIC HEALTH PLAN, OR THE COLORADO INDIGENT CARE PROGRAM.

SECTION 27. Repeal of articles being relocated in this act. Articles 4, 15, and 19 of title 26, Colorado Revised Statutes, are repealed.

SECTION 28. 1-1-104 (33.5) (b), Colorado Revised Statutes, is amended to read:

1-1-104. Definitions - repeal. As used in this code, unless the context otherwise requires:

(33.5) "Public assistance" includes, but is not necessarily limited to, assistance provided under the following programs:

(b) Programs established pursuant to the "Colorado Medical Assistance Act", ~~article 4 of title 26, C.R.S.~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.;

SECTION 29. Repeal. 2-3-1203 (3) (i) (IV), Colorado Revised Statutes, is repealed as follows:

2-3-1203. Sunset review of advisory committees. (3) The following dates are the dates for which the statutory authorization for the designated advisory committees is scheduled for repeal:

(i) July 1, 1996:

(IV) ~~The pharmacy advisory committee, appointed pursuant to section 26-4-408 (2) (a), C.R.S.;~~

SECTION 30. 8-40-301 (7), Colorado Revised Statutes, is amended to read:

8-40-301. Scope of term "employee". (7) Persons who provide host home services as part of residential services and supports, as described in section 27-10.5-104 (1) (f), C.R.S., for an eligible person, as defined in section ~~26-4-623 (2) (a)~~ 25.5-6-403 (2) (a), C.R.S., pursuant to the "Home- and Community-based Services for Persons with Developmental Disabilities Act", ~~subpart 2 of part 6 of article 4 of title 26~~ PART 4 OF ARTICLE 6 OF TITLE 25.5, C.R.S., and pursuant to a contract with a community centered board designated pursuant to section 27-10.5-105, C.R.S., or a contract with a service agency as defined in section 27-10.5-102 (28), C.R.S., shall not be considered employees of the community centered board or the service agency.

SECTION 31. 10-3-903 (2) (k), Colorado Revised Statutes, is amended to read:

10-3-903. Definition of transacting insurance business. (2) The provisions of this section do not apply to:

(k) Participation in a direct provider contracting pilot program pursuant to section ~~26-4-127~~, 25.5-5-413, C.R.S.

SECTION 32. 10-8-513 (2) (a), Colorado Revised Statutes, is amended to read:

10-8-513. Eligibility for coverage under the program. (2) The following individuals shall not be eligible for coverage under the program:

(a) Those who are eligible for health care services under the "Colorado Medical Assistance Act", ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.;

SECTION 33. 10-8-530 (1.5) (g), Colorado Revised Statutes, is amended to read:

10-8-530. Funding of program - repeal. (1.5) (g) For purposes of this subsection (1.5), "lives insured" shall be determined by rule of the commissioner; except that in no event shall "lives insured" include persons who receive health benefits through medicaid, medicare, the children's basic health plan pursuant to ~~article 19 of title 26~~ ARTICLE 8 OF TITLE 25.5, C.R.S., or the federal employees health benefit program. "Lives insured" may exclude dependent lives, at the discretion of the commissioner.

SECTION 34. 10-16-104 (6.7) (a), (6.7) (b), and (8) (a) (I), Colorado Revised Statutes, are amended to read:

10-16-104. Mandatory coverage provisions. (6.7) Medical assistance recipients - denial of coverage - liability to state. (a) No entity subject to the provisions of this article, article 8 of this title, or section 607 (1) of the federal "Employment Retirement Income Security Act of 1974", as amended, shall refuse to enroll a person for the sole reason that the person is a medical assistance recipient

for whom coverage is sought pursuant to section ~~26-4-518.5~~ 25.5-4-210, C.R.S., or refuse to accept and honor an otherwise valid claim for a covered benefit which is filed in the case of an assignment under the provisions of ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.

(b) An entity subject to this subsection (6.7) that is liable as a third party for the medical costs of a medical assistance recipient or that recovers or may recover medical costs from a third party who is liable to a medical assistance recipient for medical costs is liable to the state pursuant to section ~~26-4-403 (3)~~ 25.5-4-301 (4), C.R.S.

(8) **Availability of hospice care coverage.** (a) As used in this subsection (8), unless the context otherwise requires:

(I) "Home health services" means home health services as defined in section ~~26-4-103 (6)~~ 25.5-4-103 (7), C.R.S., which are provided by a home health agency certified by the department of public health and environment.

SECTION 35. 10-16-122 (1), Colorado Revised Statutes, is amended to read:

10-16-122. Access to prescription drugs. (1) Except as provided in section ~~26-4-115 (2) (s)~~ 25.5-5-404 (1) (u), C.R.S., any pharmacy benefit management firm or intermediary whose contract with a carrier, as defined in section 10-16-102 (8), includes an open network shall allow participation by each pharmacy provider in the contract service area. If a pharmacy benefit management firm or intermediary offers an open network, the pharmacy benefit management firm or intermediary may offer such network on a regional or local basis.

SECTION 36. 10-16-124 (5), Colorado Revised Statutes, is amended to read:

10-16-124. Prescription information cards - legislative declaration. (5) The provisions of the section shall not apply to the children's basic health plan as described in ~~article 19 of title 26~~ ARTICLE 8 OF TITLE 25.5, C.R.S.

SECTION 37. 10-16-201 (4) (a), Colorado Revised Statutes, is amended to read:

10-16-201. Form and content of individual sickness and accident insurance policies. (4) (a) No policy of sickness and accident insurance issued, renewed, or reinstated shall contain any provision which limits or excludes payments under hospital or medical benefits coverage to or on behalf of the insured because the insured or any covered dependent is eligible for or receiving medical assistance benefits under ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.

SECTION 38. 10-16-311 (2) (a), Colorado Revised Statutes, is amended to read:

10-16-311. Group benefits for depositors of banks - benefits for subscribers in public institutions. (2) (a) No certificate issued, renewed, or reinstated by a corporation subject to the provisions of part 1 of this article and this part 3 shall contain any provision which limits or excludes payments under hospital or medical benefits coverage to or on behalf of the subscriber because the subscriber or any covered dependent is eligible for or receiving medical assistance benefits under

~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.

SECTION 39. 10-16-507 (2) (a), Colorado Revised Statutes, is amended to read:

10-16-507. Enrollee coverage by prepaid dental care plan organizations.

(2) (a) No contract issued, renewed, or reinstated by a prepaid dental care plan organization shall contain any provision which limits or excludes payments under hospital or medical benefits coverage to or on behalf of the enrollee because the enrollee is eligible for or receiving medical assistance benefits under ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.

SECTION 40. 11-38-110 (3), Colorado Revised Statutes, is amended to read:

11-38-110. Treatment of reverse mortgage loan proceeds by public benefit programs. (3) This section shall apply to any law relating to means-tested programs of aid provided by this state, including but not limited to supplemental security income, low-income energy assistance, and the "Colorado Medical Assistance Act", ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.

SECTION 41. 12-22-133 (4), Colorado Revised Statutes, is amended to read:

12-22-133. Unused medication - licensed facilities - reuse - rules. (4) The board shall adopt rules that allow a pharmacist to redispense medication pursuant to this section and section ~~26-4-406.3~~ 25.5-5-502, C.R.S., and to donate medication pursuant to this section.

SECTION 42. 12-22-134, Colorado Revised Statutes, is amended to read:

12-22-134. Liability - prescription drug manufacturers. Nothing in section 12-22-133 or ~~26-4-406.3~~ 25.5-5-502, C.R.S., shall be construed to create or abrogate any liability on behalf of a prescription drug manufacturer for the storage, donation, acceptance, or dispensing of an unused donated medication or to create any civil cause of action against a prescription drug manufacturer, in addition to that which is available under applicable law.

SECTION 43. 12-38.1-102 (3.5) and (4.5), Colorado Revised Statutes, are amended to read:

12-38.1-102. Definitions - repeal. As used in this article, unless the context otherwise requires:

(3.5) "Home health agency" means a provider of home health services, as defined in section ~~26-4-103 (6)~~ 25.5-4-103 (7), C.R.S., that is certified by the department of public health and environment.

(4.5) "Nursing facility" shall have the same meaning as set forth in section ~~26-4-103 (11)~~ 25.5-4-103 (14), C.R.S.

SECTION 44. Repeal. 12-38.1-110.3 (5), Colorado Revised Statutes, is repealed as follows:

12-38.1-110.3. Medication administration advisory committee - created - department of regulatory agencies report. ~~(5) On or before September 1, 2003, the board shall provide a report to the health care task force created in section 26-15-107, C.R.S., regarding the status of implementation of the program for administration of medication by medication aides in nursing facilities. The report shall include the board's recommendations for any statutory changes related to training requirements, approval of training programs, scope of practice, licensing, and discipline procedures for medication aides. Based upon such report, the health care task force may recommend statutory changes to the general assembly no later than January 1, 2004.~~

SECTION 45. 13-3-113 (5) (b) (V) (C), Colorado Revised Statutes, is amended to read:

13-3-113. "Family-friendly Courts Act". (5) **Grant applications - duties of judicial districts.** (b) The state court administrator, in determining which judicial districts may receive grant moneys pursuant to this section, shall consider the extent that a judicial district is responsible for:

(V) Soliciting information from community-based organizations, faith communities, governmental entities, schools, community mental health centers, local nonprofit or not-for-profit agencies, local law enforcement agencies, businesses, and other community service providers about the following services and resources for the purpose of providing such information to patrons of the family-friendly court services:

(C) Information related to health insurance and health care coverage, including but not limited to the children's basic health plan and dental health plan, established pursuant to ~~article 19 of title 26~~ ARTICLE 8 OF TITLE 25.5, C.R.S., and the baby and kid care program, established pursuant to section ~~26-4-508~~ 25.5-5-205, C.R.S.;

SECTION 46. 13-9-103 (7), Colorado Revised Statutes, is amended to read:

13-9-103. Jurisdiction. (7) With respect to any trust established by or for an individual with his or her assets, income, or property of any kind, notwithstanding any statutory provision to the contrary, the court shall not authorize, direct, or ratify any trust that either has the effect of qualifying or purports to qualify the trust beneficiary for federal supplemental security income, or public or medical assistance pursuant to title 26, C.R.S., unless the trust meets the criteria set forth in sections 15-14-412.6 to 15-14-412.9, C.R.S., and any rule adopted by the medical services board pursuant to section ~~26-4-506.6~~ 25.5-6-103, C.R.S.

SECTION 47. 13-64-402 (4), Colorado Revised Statutes, is amended to read:

13-64-402. Collateral source evidence. (4) The provisions of this section shall not apply to section ~~26-4-403~~ 25.5-4-301, C.R.S.

SECTION 48. 13-80-103.5 (1) (e), Colorado Revised Statutes, is amended to read:

13-80-103.5. General limitation of actions - six years. (1) The following

actions shall be commenced within six years after the cause of action accrues, and not thereafter:

(e) All actions brought for restitution and civil penalties pursuant to section ~~26-4-1104~~ 25.5-4-306, C.R.S.

SECTION 49. 15-12-805 (1) (f.5), Colorado Revised Statutes, is amended to read:

15-12-805. Classification of claims. (1) The allowed claims against the estate of a decedent shall be paid by the personal representative in the following order:

(f.5) The claim of the department of health care policy and financing for the net amount of medical assistance, as defined in section ~~26-4-403.3 (5)~~ 25.5-4-302 (5), C.R.S., paid to or for the decedent;

SECTION 50. 15-14-412.5 (2), (5), and (6), Colorado Revised Statutes, are amended to read:

15-14-412.5. Limited court-approved arrangements authorized for persons seeking medical assistance for nursing home care - applicable to trusts established before a certain date. (2) The court shall not authorize, direct, or ratify any trust that either has the effect of qualifying or purports to qualify the trust beneficiary for medical assistance for nursing home care pursuant to the provisions of title 26, C.R.S., unless the circumstances surrounding the creation of the trust and the trust provisions meet the criteria set forth in section ~~26-4-506.5 (3)~~ 25.5-6-102 (3), C.R.S. This section shall apply to any court-approved trust that is funded with property owned by the beneficiary at the time the trust is created but shall not apply to any trust that is established and directly funded by a defendant or insurance company in settlement of an action or claim for personal injury brought by or on behalf of the trust beneficiary.

(5) The provisions of this section shall not apply if federal funds are not available for persons who would qualify for medical assistance as a result of a court-approved trust that meets the criteria set forth in section ~~26-4-506.5~~ 25.5-6-102, C.R.S.

(6) This section applies to trusts established or transfers of property made prior to July 1, 1994. The provisions set forth in sections 15-14-412.6 to 15-14-412.9 and any rule adopted by the medical services board pursuant to section ~~26-4-506.6~~ 25.5-6-103, C.R.S., apply to trusts established or property transferred on or after July 1, 1994.

SECTION 51. 15-14-412.6 (1) (c), (2), and (3), Colorado Revised Statutes, are amended to read:

15-14-412.6. Trust established by an individual - eligibility for certain public assistance programs - general provisions. (1) For purposes of this section and sections 15-14-412.7 to 15-14-412.9, unless the context otherwise requires the following definitions apply:

(c) "Public assistance" means public assistance as provided by article 2 of title 26,

C.R.S., and medical assistance as provided by ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.

(2) Notwithstanding any statutory provision to the contrary, a court shall not authorize, direct, or ratify any trust established by an individual that has the effect of qualifying or purports to qualify the trust beneficiary for public assistance unless the trust meets the criteria set forth in this section, sections 15-14-412.7 to 15-14-412.9, and any rule adopted by the medical services board pursuant to section ~~26-4-506.6~~ 25.5-6-103, C.R.S.

(3) The court shall not authorize, direct, or ratify the transfer of any assets owned by a protected person if the transfer has the effect of qualifying or purports to qualify the protected person for public assistance unless the assets are transferred to a trust that meets the criteria set forth in this section, sections 15-14-412.7 to 15-14-412.9, and any rule adopted by the medical services board pursuant to section ~~26-4-506.6~~ 25.5-6-103, C.R.S.

SECTION 52. The introductory portion to 15-14-412.7 (3) (d) and 15-14-412.7 (3) (d) (II), Colorado Revised Statutes, are amended to read:

15-14-412.7. Income trusts - limitations. (3) In order to establish or maintain income eligibility, an income trust shall meet all of the following criteria:

(d) The trust provides that deductions may be made from the monthly trust distribution to the same extent that deductions from the income of a nursing home resident or home- and community-based services client are allowed under the state medical assistance program, ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S., for nursing home residents and home- and community-based services clients who are not trust beneficiaries. Allowable deductions include the following:

(II) With respect to nursing home residents only, payments to the beneficiary's community spouse or dependent family members as provided and in accordance with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396r-5, as amended, and section ~~26-4-506~~ 25.5-6-101, C.R.S.;

SECTION 53. 15-14-412.8 (4), Colorado Revised Statutes, is amended to read:

15-14-412.8. Disability trusts - limitations. (4) No disability trust shall be valid unless the department of health care policy and financing, or its designee, has reviewed the trust and determined that the trust conforms to the requirements of this section and any rules adopted by the medical services board pursuant to section ~~26-4-506.6~~ 25.5-6-103, C.R.S.

SECTION 54. 15-14-412.9 (4), Colorado Revised Statutes, is amended to read:

15-14-412.9. Pooled trusts - limitations. (4) No pooled trust shall be valid unless the department of health care policy and financing, or its designee, has reviewed the trust and determined that the trust conforms to the requirements of this section and any rules adopted by the medical services board pursuant to section ~~26-4-506.6~~ 25.5-6-103, C.R.S.

SECTION 55. 15-15-403, Colorado Revised Statutes, is amended to read:

15-15-403. Medicaid eligibility exclusion. No person who is an applicant for or recipient of medical assistance for which it would be permissible for the department of health care policy and financing to assert a claim pursuant to section ~~26-4-403 or 26-4-403.3~~ 25.5-4-301 OR 25.5-4-302, C.R.S., shall be entitled to such medical assistance if the person has in effect a beneficiary deed. Notwithstanding the provisions of section 15-15-402 (1), the execution of a beneficiary deed by an applicant for or recipient of medical assistance as described in this section shall cause the property to be considered a countable resource in accordance with section ~~26-4-403.3 (6)~~ 25.5-4-302 (6), C.R.S., and applicable rules. ~~and regulations.~~

SECTION 56. 15-15-407 (4), Colorado Revised Statutes, is amended to read:

15-15-407. Vesting of ownership in grantee-beneficiary. (4) The interest of the grantee-beneficiary shall be subject to any claim of the department of health care policy and financing for recovery of medical assistance payments pursuant to section ~~26-4-403 or 26-4-403.3~~ 25.5-4-301 OR 25.5-4-302, C.R.S., which shall be enforced in accordance with section 15-15-409.

SECTION 57. 17-1-113.5 (1) (a), (4) (a), and (4) (c), Colorado Revised Statutes, are amended to read:

17-1-113.5. Inmates held in correctional facilities - medical benefits application assistance - county of residence - repeal. (1) (a) Except as otherwise provided in paragraph (b) of this subsection (1), on and after January 1, 2003, any person who is sentenced to a term of imprisonment in a correctional facility who was receiving medical assistance pursuant to section ~~26-4-201 (1) (i) or 26-4-301 (1) (r)~~ 25.5-5-101 (1) (f) OR 25.5-5-201 (1) (j), C.R.S., immediately prior to entering the correctional facility, or who is reasonably expected to meet eligibility criteria pursuant to section ~~26-4-201 (1) (i) or 26-4-301 (1) (r)~~ 25.5-5-101 (1) (f) OR 25.5-5-201 (1) (j), C.R.S., upon release, shall receive assistance from correctional facility personnel in applying for such medical assistance at least ninety days prior to release.

(4) (a) For purposes of determining eligibility pursuant to section ~~26-4-106~~ 25.5-4-205, C.R.S., the county of residence of the inmate held in custody shall be the county specified by the inmate as his or her county of residence upon release.

(c) On or before January 1, 2003, the department of corrections shall attempt to enter into prerelease agreements with local social security administration offices, and, if appropriate, the county departments of social services, the department of human services, or the department of health care policy and financing to simplify the processing of applications for medicaid or for supplemental security income to enroll inmates who are eligible for medical assistance pursuant to section ~~26-4-201 (1) (i) or 26-4-301 (1) (r)~~ 25.5-5-101 (1) (f) OR 25.5-5-201 (1) (j), C.R.S., effective upon release and to provide such inmates with the information and paperwork necessary to access medical assistance immediately upon release.

SECTION 58. 17-10-103 (4), Colorado Revised Statutes, is amended to read:

17-10-103. Action for reimbursement of cost of care. (4) After the set-offs for restitution and for maintenance and support as provided in subsection (3) of this section, any amounts recovered pursuant to this section that are available to reimburse the costs of providing medical care shall be used to reimburse the state for the state's financial participation for medical assistance if medical care is provided for the inmate or an infant of a female inmate under the "Colorado Medical Assistance Act", ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.

SECTION 59. The introductory portion to 17-26-104.5 (1.3), Colorado Revised Statutes, is amended to read:

17-26-104.5. Medical visits - charge to persons in custody - provider charges - state hospital in Pueblo. (1.3) A provider of medical care that receives any state money, including but not limited to providers that receive money from the medical assistance program established in ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S., or the COLORADO INDIGENT CARE program ~~for the medically indigent established in article 15 of title 26~~ PART 1 OF ARTICLE 3 OF TITLE 25.5, C.R.S., shall charge a county for medical care provided to a person in custody in a county jail:

SECTION 60. 18-1-202 (7) (b) (II) (N), Colorado Revised Statutes, is amended to read:

18-1-202. Place of trial. (7) (b) (II) The provisions of subparagraph (I) of this paragraph (b) shall apply to the following offenses:

(N) Unlawful use of a patient personal needs trust fund, as defined in section ~~26-4-504~~ 25.5-6-206, C.R.S.;

SECTION 61. 18-1.3-701 (6), Colorado Revised Statutes, is amended to read:

18-1.3-701. Judgment for costs and fines. (6) After the set-offs for restitution and for maintenance and support as provided in subsection (4) of this section, any amounts recovered pursuant to this section that are available to reimburse the costs of providing medical care shall be used to reimburse the state for the state's financial participation for medical assistance if medical care is provided for the inmate or an infant of a female inmate under the "Colorado Medical Assistance Act", ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.

SECTION 62. 22-2-112 (1) (n), Colorado Revised Statutes, is amended to read:

22-2-112. Commissioner - duties. (1) Subject to the supervision of the state board, the commissioner has the following duties:

(n) To enter into an interagency agreement with the department of health care policy and financing and to promulgate such rules and regulations as may be necessary under the agreement to enable school districts, boards of cooperative services, and state educational institutions to enter into contracts and to receive federal matching funds for moneys spent in providing student health services as provided in section ~~26-4-513 (6) or 26-4-531~~ 25.5-5-301 (6) OR 25.5-5-318, C.R.S.;

SECTION 63. 22-5-108 (1) (h), Colorado Revised Statutes, is amended to read:

22-5-108. Powers of board of cooperative services. (1) In addition to any other powers granted by law, the board of cooperative services shall have the following specific powers, to be exercised in its judgment:

(h) To enter into contracts and to receive federal matching funds for moneys spent in providing student health services pursuant to section ~~26-4-513 (6) or 26-4-531~~ 25.5-5-301 (6) OR 25.5-5-318, C.R.S.

SECTION 64. 22-32-110 (1) (ii), Colorado Revised Statutes, is amended to read:

22-32-110. Board of education - specific powers. (1) In addition to any other power granted to a board of education of a school district by law, each board of education of a school district shall have the following specific powers, to be exercised in its judgment:

(ii) To enter into contracts and to receive federal matching funds for moneys spent in providing student health services pursuant to section ~~26-4-513 (6) or 26-4-531~~ 25.5-5-301 (6) OR 25.5-5-318, C.R.S.;

SECTION 65. 22-80-102 (5), Colorado Revised Statutes, is amended to read:

22-80-102. Educational institution. (5) The school may enter into contracts and receive federal matching funds for moneys spent in providing student health services as provided in section ~~26-4-513 (6) or 26-4-531~~ 25.5-5-301 (6) OR 25.5-5-318, C.R.S.

SECTION 66. 23-21-501 (1) (f), Colorado Revised Statutes, is amended to read:

23-21-501. Legislative declaration. (1) The general assembly hereby finds and declares that:

(f) Subject to the provisions of section ~~26-15-102 (2)~~ 25.5-3-102 (2), C.R.S., the authority to be created pursuant to this part 5 to operate the university of Colorado university hospital by receiving its assets and operating obligations shall continue to subsidize the costs of delivering medically indigent care in excess of the state reimbursement for the medically indigent. Consistent with the university of Colorado university hospital's past policy and performance, the authority will make every reasonable effort to continue the hospital's historic commitment to the provision of uncompensated care and shall allocate and invest its resources with a view to maximizing the hospital's long-term ability to provide uncompensated care.

SECTION 67. 23-21-504 (1), Colorado Revised Statutes, is amended to read:

23-21-504. Mission of the authority - obligation to provide uncompensated care - action of the board of directors. (1) The mission of the authority shall be the operation of university hospital as a state of the art teaching and research hospital providing comprehensive medical care, including tertiary care, and patient care of limited availability. The authority shall also provide space and facilities as necessary for the operation of the clinical programs of the health sciences schools at the health sciences center together with the university of Colorado psychiatric hospital, and, subject to the provisions of section ~~26-15-102 (2)~~ 25.5-3-102 (2),

C.R.S., the provision of medical care to those eligible for payment assistance through any program for the benefit of the medically indigent. For every three dollars of moneys appropriated by the general assembly that is distributed to the authority for the state medically indigent program, the authority shall provide four dollars worth of medically indigent care.

SECTION 68. 24-1-119.5 (2), (4), (4.5), and (6), Colorado Revised Statutes, are amended to read:

24-1-119.5. Department of health care policy and financing - creation.

(2) The powers, duties, and functions relating to the "Colorado Medical Assistance Act", as specified in ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S., are transferred by a **type 2** transfer to the department of health care policy and financing.

(4) The powers, duties, and functions relating to the ~~"Reform Act for the Provision of Health Care for the Medically Indigent"~~ "COLORADO INDIGENT CARE PROGRAM", as specified in ~~article 15 of title 26~~ PART 1 OF ARTICLE 3 OF TITLE 25.5, C.R.S., are transferred by a **type 2** transfer to the department of health care policy and financing.

(4.5) The powers, duties, and functions relating to the old age pension health and medical care program and the supplemental old age pension health and medical care program, as specified in section ~~26-2-117~~ 25.5-2-101, C.R.S., are transferred by a **type 2** transfer to the department of health care policy and financing.

(6) ~~The cooperative health care agreements board, created in part 27 of article 32 of this title, and its powers, duties, and functions are transferred by a type 2 transfer to the office of the executive director of the department of health care policy and financing.~~

SECTION 69. 24-21-104 (3) (d) (VIII), Colorado Revised Statutes, is amended to read:

24-21-104. Fees of secretary of state. (3) (d) (VIII) Notwithstanding any provision of paragraph (b) of this subsection (3) to the contrary, on July 1, 1998, the state treasurer shall deduct one million seven hundred thousand dollars from the department of state cash fund and transfer such sum to the children's basic health plan trust fund created in section ~~26-19-105~~ 25.5-8-105, C.R.S.

SECTION 70. 24-22-115 (1), Colorado Revised Statutes, is amended to read:

24-22-115. Tobacco litigation settlement cash fund - creation. (1) There is hereby created in the state treasury the tobacco litigation settlement cash fund. The cash fund shall consist of all moneys transmitted to the state treasurer in accordance with the terms of the master settlement agreement, the smokeless tobacco master settlement agreement, and the consent decree approved and entered by the court in the case denominated *State of Colorado, ex rel. Gale A. Norton, Attorney General v. R.J. Reynolds Tobacco Co.; American Tobacco Co., Inc.; Brown & Williamson Tobacco Corp.; Liggett & Myers, Inc.; Lorillard Tobacco Co., Inc.; Philip Morris, Inc.; United States Tobacco Co.; B.A.T. Industries, P.L.C.; The Council For*

Tobacco Research--U.S.A., Inc.; and Tobacco Institute, Inc., Case No. 97 CV 3432, in the district court for the city and county of Denver other than moneys credited to the tobacco litigation settlement trust fund pursuant to section 24-22-115.5. Except as provided in subsection (2) of this section, all interest derived from the deposit and investment of moneys in the cash fund shall be credited to the cash fund; except that, beginning with the fiscal year 2001-02, and each fiscal year thereafter, all interest derived from the deposit and investment of moneys in the cash fund shall be credited to the breast and cervical cancer prevention and treatment fund created pursuant to section ~~26-4-532~~ 25.5-5-308, C.R.S. Except as provided in subsection (2) of this section, all moneys in the cash fund shall be subject to appropriation by the general assembly for such purposes as may be authorized by law in accordance with the terms of the settlement agreements and the consent decree. Except as provided in subsection (2) of this section, at the end of the 2004-05 fiscal year and at the end of each succeeding fiscal year, but prior to the making of any transfer of moneys from the cash fund to the general fund at the end of the fiscal year as required by this subsection (1), an amount needed, up to one million dollars, to pay the state's share of the annual funding required by the "Home- and Community-based Services for Children with Autism Act", ~~subpart 7 of part 6 of article 4 of title 26~~ PART 8 OF ARTICLE 6 OF TITLE 25.5, C.R.S., shall be transferred from the cash fund to the Colorado autism treatment fund created pursuant to section ~~26-4-695~~ 25.5-6-805, C.R.S. Except as provided in subsection (2) of this section, at the end of any fiscal year commencing on or after July 1, 2004, all unexpended and unencumbered moneys and all moneys not appropriated for the following fiscal year in the cash fund shall be transferred to the general fund.

SECTION 71. 24-22-117 (1) (c) (I) (B), (1) (c) (II), (2) (a) (II), and (2) (b) (II), the introductory portion to 24-22-117 (2) (d) (II), and 24-22-117 (2) (d) (IV) (A) and (2) (e), Colorado Revised Statutes, are amended to read:

24-22-117. Tobacco tax cash fund - accounts - creation - repeal. (1) (c) For the 2004-05 fiscal year and each fiscal year thereafter, the general assembly shall annually appropriate three percent of the moneys estimated to be deposited in that fiscal year into the cash fund, plus three percent of the interest earned on the moneys in the cash fund, for health-related purposes to provide revenue for the state's general fund and old age pension fund and for municipal and county governments to compensate proportionately for tax revenue reductions attributable to lower cigarette and tobacco sales resulting from the implementation of the tax imposed pursuant to section 21 of article X of the state constitution, as follows:

(I) (B) Beginning in fiscal year 2006-07 and for each fiscal year thereafter, of the moneys specified in sub-subparagraph (A) of this subparagraph (I), fifty percent shall be appropriated for the purposes of providing immunizations performed by county public health nursing services and fifty percent shall be appropriated to the pediatric specialty hospital fund, created in paragraph (e) of subsection (2) of this section, for the purposes of augmenting hospital reimbursement rates for regional pediatric trauma centers as defined in section 25-3.5-703 (4) (f), C.R.S., under the "Colorado Medical Assistance Act", ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.

(II) Fifty percent of the moneys specified in this paragraph (c) to the supplemental old age pension health and medical care fund to provide services under the

supplemental health and medical care program, section ~~26-2-117(3)~~ 25.5-2-101 (3), C.R.S., for persons who qualify to receive old age pensions; and

(2) There are hereby created in the state treasury the following funds:

(a) (II) Except as provided in subparagraph (III) of this paragraph (a), for fiscal year 2005-06 and each fiscal year thereafter, moneys in the health care expansion fund shall be annually appropriated by the general assembly to the department of health care policy and financing for the following purposes:

(A) To increase eligibility in the children's basic health plan, ~~article 19 of title 26~~ ARTICLE 8 OF TITLE 25.5, C.R.S., for children and pregnant women from one hundred eighty-five percent to two hundred percent of the federal poverty level;

(B) To remove the asset test under the medical assistance program, ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S., for children and families;

(C) To expand the number of children that can be enrolled in the children's home- and community-based service waiver program, section ~~26-4-509~~ 25.5-6-901, C.R.S., and the children's extensive support waiver program;

(D) To increase eligibility in the medical assistance program, ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S., to at least sixty percent of the federal poverty level for a parent of a child who is eligible for the medical assistance program or the children's basic health plan, ~~article 19 of title 26~~ ARTICLE 8 OF TITLE 25.5, C.R.S.;

(E) To fund medical assistance to legal immigrants pursuant to section ~~26-4-301~~ 25.5-5-201, C.R.S.;

(F) To pay for enrollment increases above the average enrollment for state fiscal year 2003-04 in the children's basic health plan, ~~article 19 of title 26~~ ARTICLE 8 OF TITLE 25.5, C.R.S.;

(G) To provide up to five hundred forty thousand dollars for cost-effective marketing to increase the enrollment of eligible children and pregnant women in the children's basic health plan, ~~article 19 of title 26~~ ARTICLE 8 OF TITLE 25.5, C.R.S.; and

(H) To provide presumptive eligibility to pregnant women under the medical assistance program, ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.

(b) (II) For fiscal year 2005-06 and each fiscal year thereafter, moneys in the primary care fund shall be annually appropriated by the general assembly to the department of health care policy and financing for comprehensive primary care as specified in PART 3 OF article 3 of title 25.5, C.R.S.

(d) (II) Of the moneys appropriated annually by the general assembly to the department of public health and environment pursuant to subparagraph (I) of this paragraph (d), moneys shall be annually allocated by the department of public health and environment for breast and cervical cancer screenings pursuant to section

25-4-1505, C.R.S., and transferred to the department of health care policy and financing for the breast and cervical cancer treatment program established in section ~~26-4-532~~ 25.5-5-308, C.R.S., in the following amounts not to exceed five million dollars in any fiscal year:

(IV) (A) For fiscal years 2005-06 and 2006-07, after the allocation and transfer required by subparagraphs (II) and (III) of this paragraph (d), two million dollars shall be transferred to the department of health care policy and financing for medicaid disease management programs, authorized by section ~~26-4-408.5~~ 25.5-5-316, C.R.S., that address cancer, heart disease, and lung disease.

(e) The pediatric specialty hospital fund to be administered by the department of health care policy and financing. For fiscal year 2006-07 and for each fiscal year thereafter, moneys in the pediatric specialty hospital fund shall be annually appropriated by the general assembly to the department of health care policy and financing to augment hospital reimbursement rates for regional pediatric trauma centers as defined in section 25-3.5-703 (4) (f), C.R.S., under the "Colorado Medical Assistance Act", ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.

SECTION 72. The introductory portion to 24-30-202 (12), Colorado Revised Statutes, is amended to read:

24-30-202. Procedures - vouchers and warrants - rules - penalties. (12) The controller shall prescribe and cause to be installed a unified and integrated system of accounts for the state. Except as otherwise provided in sections 24-75-201 (2) and ~~26-4-110.7~~ 25.5-4-201, C.R.S., such system shall be based upon the accrual system of accounting, as enunciated by the governmental accounting standards board, which shall include:

SECTION 73. 24-34-104 (39) (b) (XV) and (41) (q), Colorado Revised Statutes, are amended to read:

24-34-104. General assembly review of regulatory agencies and functions for termination, continuation, or reestablishment. (39) (b) The following agencies, functions, or both, shall terminate on July 1, 2008:

(XV) In-home support services, established pursuant to ~~part 14 of article 4 of title 26~~ PART 12 OF ARTICLE 6 OF TITLE 25.5, C.R.S.;

(41) The following agencies, functions, or both, shall terminate on July 1, 2010:

(q) The obesity treatment pilot program implemented by the department of health care policy and financing pursuant to section ~~26-4-534~~ 25.5-5-317, C.R.S.;

SECTION 74. 24-50-603 (10), Colorado Revised Statutes, is amended to read:

24-50-603. Definitions. As used in this part 6, unless the context otherwise requires:

(10) "Medicaid" means federal insurance or assistance as such is provided by the

provisions of Title XIX of the federal "Social Security Act" and the "Colorado Medical Assistance Act", ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.

SECTION 75. 24-60-2404 (2) (b), Colorado Revised Statutes, is amended to read:

24-60-2404. Contents of compact. (2) Any compact entered into by the department of human services pursuant to this part 24 shall contain and implement the following provisions regarding medical assistance:

(b) That the department of health care policy and financing shall consider the holder of a medical assistance identification specified in paragraph (a) of this subsection (2) as any other holder of a medical assistance identification under the laws of this state and shall process and make payment on claims on account of such holder in the same manner and pursuant to the same conditions and procedures as for other recipients of medical assistance pursuant to ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.;

SECTION 76. The introductory portion to 24-75-201 (2) (a) (II), Colorado Revised Statutes, is amended to read:

24-75-201. General fund - general fund surplus - custodial moneys. (2) (a) The general fund surplus shall be determined based upon the accrual system of accounting, as enunciated by the governmental accounting standards board; except that:

(II) General fund revenues shall be restricted only upon the issuance of a commitment voucher to the state controller by the department of health care policy and financing for the payment of a sufficient claim that warrants reimbursement in accordance with the "Colorado Medical Assistance Act", ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S., from general fund revenues appropriated for:

SECTION 77. 24-75-217 (3) (b), Colorado Revised Statutes, is amended to read:

24-75-217. Restoration of funds transferred to augment the general fund for the 2001-02 fiscal year. (3) The funds that shall be restored pursuant to subsection (1) of this section include:

(b) The children's basic health plan trust created in section ~~26-19-105 (1)~~ 25.5-8-105 (1), C.R.S.;

SECTION 78. 24-75-302.5 (6) (a), Colorado Revised Statutes, is amended to read:

24-75-302.5. Controlled maintenance - trust fund. (6) (a) Notwithstanding any provision of this section to the contrary, on February 1, 2006, the state treasurer and the controller shall transfer three million one hundred forty-four thousand one hundred sixty-two dollars from the interest earned on the principal of the trust fund balance to the general fund to be used to increase the general fund appropriation for

safety net provider payments for private hospitals under the Colorado indigent care program created in ~~part 1 of article 15 of title 26~~ PART 1 OF ARTICLE 3 OF TITLE 25.5, C.R.S.

SECTION 79. 24-75-1104.5 (1) (b) and (1) (c), Colorado Revised Statutes, are amended to read:

24-75-1104.5. Use of settlement moneys - programs. (1) For the 2004-05 fiscal year and for each fiscal year thereafter, the following programs, services, or funds shall receive appropriations in the specified amounts from the settlement moneys annually received by the state:

(b) The comprehensive primary and preventive care grant program created in ~~part 10 of article 4 of title 26~~ PART 2 OF ARTICLE 3 OF TITLE 25.5, C.R.S., shall receive three percent of the total amount of settlement moneys annually received by the state, not to exceed five million dollars in any fiscal year.

(c) The children's basic health plan trust created in section ~~26-19-105~~ 25.5-8-105, C.R.S., shall receive twenty-four percent of the total amount of settlement moneys annually received by the state, not to exceed thirty million dollars in any fiscal year. If in any fiscal year the percentage of settlement moneys specified in this paragraph (c) does not equal at least seventeen million five hundred thousand dollars, the amount of the shortfall shall be allocated out of the tobacco litigation settlement trust fund pursuant to section 24-22-115.5 (2) (a.7) (I) and, if necessary, out of the amount of settlement moneys transferred to the general fund pursuant to section 24-22-115 (3).

SECTION 80. 25-1-107.5 (4) (a), Colorado Revised Statutes, is amended to read:

25-1-107.5. Additional authority of the department - remedies against nursing facilities - criteria for recommending assessments for civil penalties - cooperation with the department of health care policy and financing - nursing home penalty cash fund. (4) (a) The department of health care policy and financing, after receiving a recommendation from the department, is authorized to assess, enforce, and collect the civil money penalty pursuant to section ~~26-4-505~~ 25.5-6-205, C.R.S., for credit to the nursing home penalty cash fund, created pursuant to section ~~26-4-505 (3) (a)~~ 25.5-6-205 (3) (a), C.R.S.

SECTION 81. 25-1-120 (6) and (8) (a), Colorado Revised Statutes, are amended to read:

25-1-120. Nursing facilities - rights of patients. (6) Implementation of this section shall be pursuant to section ~~26-4-410~~ 25.5-6-204, C.R.S.

(8) (a) A patient who is eligible to receive medicaid benefits pursuant to ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S., and who qualifies for nursing facility care shall have the right to select any nursing care facility recommended for certification by the department of public health and environment under Title XIX of the federal "Social Security Act", as amended, as a provider of medicaid services and licensed by the department pursuant to article 3 of this title

where space is available, and the department of health care policy and financing shall reimburse the selected facility for services pursuant to section ~~26-4-410~~ 25.5-6-204, C.R.S., unless such nursing care facility shall have been notified by the department of health care policy and financing that it may not qualify as a provider of medicaid services.

SECTION 82. 25-1-124.5 (2) (a), (2) (b), (2) (c), and (2) (d), Colorado Revised Statutes, are amended to read:

25-1-124.5. Nursing care facilities - employees - criminal history check. (2) As used in this section, "nursing care facility" includes, but is not limited to:

- (a) A nursing facility as defined in section ~~26-4-103 (11)~~ 25.5-4-103 (14), C.R.S.;
- (b) An intermediate nursing facility for the mentally retarded as defined in section ~~26-4-103 (8)~~ 25.5-4-103 (9), C.R.S.;
- (c) An adult day care facility as defined in section ~~26-4-603 (1)~~ 25.5-6-303 (1), C.R.S.;
- (d) An alternative care facility as defined in section ~~26-4-603 (3)~~ 25.5-6-303 (3), C.R.S.;

SECTION 83. 25-1-213, Colorado Revised Statutes, is amended to read:

25-1-213. Alcohol and drug and addiction counseling and treatment - necessary components. Any entity that qualifies to provide services pursuant to section ~~26-4-302 (1) (s)~~ 25.5-5-202 (1) (r), C.R.S., in regard to the treatment program for high-risk pregnant women, shall make available, in addition to alcohol and drug and addiction counseling and treatment: Risk assessment services; care coordination; nutrition assessment; psychosocial counseling; intensive health education, including but not limited to parenting education and education on risk factors and appropriate health behaviors; home visits; transportation services; and other services deemed necessary by the division of alcohol and drug abuse of the department of human services and the department of health care policy and financing.

SECTION 84. 25-1-214, Colorado Revised Statutes, is amended to read:

25-1-214. Treatment program for high-risk pregnant women - cooperation with private entities. The department of health care policy and financing shall cooperate with any private entities which desire to assist such department in the provision of services connected with the treatment program for high-risk pregnant women. Private entities may provide services which are not provided to persons pursuant to the treatment program for high-risk pregnant women, ~~and articles 2 and 4 of title 26, C.R.S.~~ ARTICLE 2 OF TITLE 26, C.R.S., AND ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S., which may include, but shall not be limited to, needs assessment services, preventive services, rehabilitative services, care coordination, nutrition assessment, psychosocial counseling, intensive health education, home visits, transportation, development of provider training, child care, and other necessary components of residential or outpatient treatment or care.

SECTION 85. 25-1-1003 (3), Colorado Revised Statutes, is amended to read:

25-1-1003. Grant program - requirements - use of medical assistance funds prohibited. (3) No medical assistance funds under the "Colorado Medical Assistance Act", ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S., shall be used to subsidize the cost of operating a day care center or day care program in a nursing home facility.

SECTION 86. 25-1.5-301 (2) (d) and (2) (i), Colorado Revised Statutes, are amended to read:

25-1.5-301. Definitions. As used in this part 3, unless the context otherwise requires:

(2) "Facility" means:

(d) Alternate care facilities provided for in section ~~26-4-603 (3)~~ 25.5-6-303 (3), C.R.S.;

(i) Adult day care facilities providing services in support of persons as defined in section ~~26-4-603 (1)~~ 25.5-6-303 (1), C.R.S.

SECTION 87. 25-3-102.5 (1) (a), Colorado Revised Statutes, is amended to read:

25-3-102.5. Nursing facilities - consumer satisfaction survey - pilot survey. (1)(a) The department shall develop and implement a consumer satisfaction survey based on the results of the pilot survey implemented pursuant to paragraph (a.5) of this subsection (1). The pilot survey and the resulting consumer satisfaction survey shall be implemented to determine the level of satisfaction among residents and residents' families regarding the quality of care and quality of living in nursing facilities. "Nursing facility", as used in this section, means a nursing facility as defined in section ~~26-4-103 (11)~~ 25.5-4-103 (14), C.R.S. The department shall appoint an advisory committee to develop the consumer satisfaction survey. The advisory committee shall include, but not be limited to, the state ombudsman, representatives of senior groups, representatives of the disabled community, representatives of providers of long term care services, and long term care consumers or their family members. The advisory committee shall develop recommendations for the development of an assessment tool for the consumer satisfaction survey and shall develop recommendations for the implementation of the pilot survey and the consumer satisfaction survey. The advisory committee shall ensure that a representative sample of participants are chosen and surveyed in a manner that will yield accurate and useful results. The department shall ensure that every nursing facility licensed by the department participates in the assessment of consumer satisfaction; except that any nursing facility that accepts exclusively private pay residents shall not be required to participate. Information about results of the most recent consumer satisfaction survey and how such survey was conducted shall be included by the facility in all informational materials provided to persons who inquire about the facility. The department shall assure confidentiality for residents during the survey process. The department shall make the results of consumer satisfaction surveys available to the public.

SECTION 88. 25-3-103 (5), Colorado Revised Statutes, is amended to read:

25-3-103. License denial or revocation - provisional license. (5) The department of public health and environment may suspend or revoke the license for the operation of a nursing care facility or intermediate care facility of any licensee convicted of violating any provision of section 26-1-127 or section ~~26-4-504 (8)~~ 25.5-6-206 (8), C.R.S., if the department finds such suspension or revocation necessary to safeguard the rights of patients in the future. No license or permit shall thereafter be issued to any person so convicted, except upon a specific finding by the department that the rights of the patients will have adequate safeguards.

SECTION 89. 25-3-108 (7), Colorado Revised Statutes, is amended to read:

25-3-108. Receivership. (7) The department of public health and environment shall grant the receiver a license pursuant to section 25-3-102 and shall recommend certification for medicaid participation, and the department of health care policy and financing shall reimburse the receiver for the long-term health care facility's medicaid residents pursuant to section ~~26-4-410~~ 25.5-6-204, C.R.S.

SECTION 90. 25-4-1703 (3), Colorado Revised Statutes, is amended to read:

25-4-1703. Definitions. As used in this part 17, unless the context otherwise requires:

(3) "Infant" means any child up to twenty-four months of age or any child eligible for vaccination and enrolled under the "Colorado Medical Assistance Act", ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.

SECTION 91. 25-4-1707, Colorado Revised Statutes, is amended to read:

25-4-1707. Moneys targeted for medical assistance for infants - reimbursement. The state department of ~~human services~~ HEALTH CARE POLICY AND FINANCING shall reimburse the department of public health and environment for the costs of vaccinating infants under the infant immunization program who are medicaid eligible pursuant to the "Colorado Medical Assistance Act", ~~part 1 of article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S. Such moneys received from the state department of ~~human services~~ HEALTH CARE POLICY AND FINANCING shall be credited to the infant immunization fund.

SECTION 92. 25-23-102 (5) (a), (5) (b), and (5) (c), Colorado Revised Statutes, are amended to read:

25-23-102. Definitions. As used in this article, unless the context otherwise requires:

(5) "Underserved population" includes but is not limited to:

(a) Individuals eligible for medical assistance under ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.;

(b) Individuals enrolled in the children's basic health plan pursuant to ~~article 19~~

~~of title 26~~ ARTICLE 8 OF TITLE 25.5, C.R.S.;

(c) Individuals eligible for medical services pursuant to the COLORADO INDIGENT CARE program ~~for the medically indigent set forth in article 15 of title 26~~ PART 1 OF ARTICLE 3 OF TITLE 25.5, C.R.S.;

SECTION 93. 25-27-113 (1), Colorado Revised Statutes, is amended to read:

25-27-113. Fees for providers with high medicaid utilization and disproportionate low-income residences. (1) The general assembly hereby finds, determines, and declares that assisted living residences provide necessary services to many residents who receive medicaid benefits pursuant to ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S. Because so many Coloradans benefit from assisted living centers that serve medicaid recipients, the general assembly hereby finds, determines, and declares that assisted living residences that have high medicaid utilization should receive a modified fee schedule for fees required by this article.

SECTION 94. 26-1-105.5 (1) (b), Colorado Revised Statutes, is amended to read:

26-1-105.5. Transfer of functions - employees - property - records. (1) (b) ON AND AFTER JULY 1, 2006, the provisions of this section shall not apply to the functions, employees, and property transferred under the provisions of sections 24-1-119.5, C.R.S., and 25.5-1-105, C.R.S., concerning the "Colorado Medical Assistance Act", ~~health care for the medically indigent, adult foster care, home care allowance;~~ THE COLORADO INDIGENT CARE PROGRAM, and the treatment program for high-risk pregnant women.

SECTION 95. 26-1-302 (9), Colorado Revised Statutes, is amended to read:

26-1-302. Colorado traumatic brain injury board - creation - powers and duties. (9) ~~Article 4 of this title~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S., shall not apply to the promulgation of any policies or procedures authorized by subsection (8) of this section.

SECTION 96. 26-1-304 (2), Colorado Revised Statutes, is amended to read:

26-1-304. Services for persons with traumatic brain injuries - limitations - covered services. (2) To be eligible for assistance from the trust fund, an individual shall have exhausted all other health or rehabilitation benefit funding sources that cover the services provided by the trust fund. An individual shall not be required to exhaust all private funds in order to be eligible for the program. Individuals who have continuing health insurance benefits, including, but not limited to, medical assistance pursuant to ~~article 4 of this title~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S., may access the trust fund for services that are necessary but that are not covered by a health benefit plan, as defined in section 10-16-102 (21), C.R.S., or any other funding source.

SECTION 97. 26-2-111.6 (1), Colorado Revised Statutes, is amended to read:

26-2-111.6. Old age pension work incentive program. (1) The state department is authorized to implement a work incentive program for persons receiving old age pension benefits, which program shall be called the old age pension work incentive program. Under this program, a person who is already eligible for and receiving old age pension benefits would be allowed to retain sixty-five dollars of earned income in a month and one-half of the remaining earned income in a month without such moneys being counted as income for purposes of eligibility for the old age pension. In addition, the receipt and retention of such earned income shall not affect the person's eligibility for medical assistance as provided by ~~article 4 of this title~~. ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.

SECTION 98. 26-2-119 (1.5), Colorado Revised Statutes, is amended to read:

26-2-119. Amount of assistance payments - aid to the needy disabled. (1.5) (a) In addition to the amount of assistance available pursuant to subsection (1) of this section, the ~~medical services~~ STATE board in the STATE department, ~~of health care policy and financing~~, with the consent of the general assembly and subject to available funds, may provide adult foster care for persons eligible to receive aid to the needy disabled. For the purposes of this paragraph (a), "adult foster care" means the care and services defined in section 26-2-122.3.

(b) In addition to the amount of assistance available pursuant to subsection (1) of this section, the ~~medical services~~ STATE board in the STATE department, ~~of health care policy and financing~~, with the consent of the general assembly and subject to available funds, may provide a home care allowance for persons eligible to receive aid to the needy disabled. For the purposes of this paragraph (b), "home care allowance" means care and services defined in section 26-2-122.3.

SECTION 99. 26-2-120 (1.5), Colorado Revised Statutes, is amended to read:

26-2-120. Amount of assistance payments - aid to the blind. (1.5) (a) In addition to the amount of assistance available pursuant to subsection (1) of this section, the ~~medical services~~ STATE board, with the consent of the general assembly and subject to available funds, may provide adult foster care for persons eligible to receive aid to the blind. For the purposes of this paragraph (a), "adult foster care" means the care and services defined in section 26-2-122.3.

(b) In addition to the amount of assistance available pursuant to subsection (1) of this section, the ~~medical services~~ STATE board, with the consent of the general assembly and subject to available funds, may provide a home care allowance for persons eligible to receive aid to the blind. For the purposes of this paragraph (b), "home care allowance" means care and services defined in section 26-2-122.3.

SECTION 100. 26-2-133 (2), Colorado Revised Statutes, is amended to read:

26-2-133. State income tax refund offset. (2) As a condition of certifying an overpayment to the department of revenue as provided in subsection (1) of this section, the state department shall ensure that the obligated person has been afforded the opportunity for a conference at the county department level pursuant to section 26-2-127 or ~~26-4-402~~ 25.5-4-207, C.R.S. and the opportunity for an appeal to the state department pursuant to section 26-2-127 or 26-2-304. In addition, the state

department, prior to final certification of the information specified in subsection (1) of this section to the department of revenue, shall notify the obligated person, in writing, at his last known address, that the state intends to refer the person's name to the department of revenue in an attempt to offset the obligation against the person's state income tax refund. Such notification shall inform the obligated person of the opportunity for a conference with the county department pursuant to section 26-2-127 or ~~26-4-402~~ 25.5-4-207, C.R.S., and of the opportunity for an appeal to the state department pursuant to section 26-2-127 or 26-2-304. In addition, the notice shall specify issues that may be raised at an evidentiary conference or on appeal, as provided by this subsection (2), by the obligated person in objecting to the offset and shall specify that the obligated person may not object to the fact that an overpayment occurred. A person who has received a notice pursuant to this subsection (2) shall request, within thirty days from the date such notice was mailed, an administrative review or evidentiary conference, as provided in this subsection (2).

SECTION 101. 26-2-711 (4), Colorado Revised Statutes, is amended to read:

26-2-711. Works program sanctions against participants. (4) In no event shall a county department impose any sanction on a participant that adversely affects the participant's receipt of food stamps beyond those allowable sanctions provided for in federal REGULATIONS and state ~~regulations~~ RULES or medical assistance pursuant to the provisions of ~~article 4 of this title~~. ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.

SECTION 102. 26-2-716 (9), Colorado Revised Statutes, is amended to read:

26-2-716. County duties - appropriations - penalties - hardship extensions - domestic violence extensions - incentives. (9) County departments shall assist families in completing the reporting requirements for transitional medicaid. This shall include informing 1931 medicaid recipients, as defined in section ~~26-4-103 (1)~~ 25.5-4-103 (1), C.R.S., of the transitional medicaid eligibility requirements and the required reporting calendar.

SECTION 103. 26-2-717 (1) (h), Colorado Revised Statutes, is amended to read:

26-2-717. Reporting requirements. (1) The state department shall submit the following general case record information on participants to the federal government as required by the personal responsibility and work opportunity reconciliation act and as reported by a county department pursuant to section 26-2-716 (2) (d):

(h) Whether the family has received subsidized housing, medical assistance pursuant to ~~article 4 of this title~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S., food stamps, or subsidized child care, and if the latter two, the amount received;

SECTION 104. 26-5.7-108 (4) (a), Colorado Revised Statutes, is amended to read:

26-5.7-108. Voluntary alternative residence - lack of parental agreement. (4) (a) For the purposes of this article, a voluntary residential agreement shall not require the county department to assume custody of the youth or to exercise any

parental power or control over the youth or require ~~medicaid~~ MEDICAL assistance under ~~article 4 of this title~~. ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.

SECTION 105. 26-11.5-103 (3) (a), Colorado Revised Statutes, is amended to read:

26-11.5-103. Definitions. As used in this article, unless the context otherwise requires:

(3) "Long-term care facility" or "facility" means:

(a) A nursing care facility as defined in section ~~26-4-103(11)~~ 25.5-4-103 (14), C.R.S.;

SECTION 106. 26-12-120 (1), Colorado Revised Statutes, is amended to read:

26-12-120. Intestate estate - escheat. (1) If a resident dies without legal heirs and without a will disposing of his or her estate, all of the property, real and personal, shall pass to the state of Colorado for the sole use and benefit of the state nursing home in which the resident lived at the time of his or her death, subject to the provisions of section ~~26-4-403.3~~ 25.5-4-302, C.R.S., and subsection (2) of this section.

SECTION 107. 26-13-102.5 (2), Colorado Revised Statutes, is amended to read:

26-13-102.5. Definitions. As used in this article, unless the context otherwise requires:

(2) "IV-D case" or "IV-D support order" means a case or a support order with respect to a child in which support enforcement services are provided, in accordance with Title IV-D of the federal "Social Security Act", as amended, and pursuant to this article, by the delegate child support enforcement unit to a custodian of a child who is a recipient of aid to families with dependent children, or is a recipient of medical assistance only under ~~article 4 of this title~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S., or is a recipient of Title IV-E foster care. The terms also include any case or order in which the custodian of a child applies to the delegate child support enforcement unit for support enforcement services and pays a fee for such services under section 26-13-106 (2).

SECTION 108. 27-10.3-103 (1), Colorado Revised Statutes, is amended to read:

27-10.3-103. Definitions. As used in this article, unless the context otherwise requires:

(1) "Child at risk of out-of-home placement" means a child who has been diagnosed as a mentally ill person, as defined in section 27-10-102 (7), and who requires the level of care provided in a residential child care facility pursuant to section ~~26-4-527~~ 25.5-5-306, C.R.S., and who, although not otherwise categorically eligible for medicaid, is determined to be eligible for social security income and therefore medicaid-eligible because of the child's need for mental health services and for whom it is not appropriate or warranted to file an action in dependency or

neglect pursuant to article 3 of title 19, C.R.S.

SECTION 109. 27-10.3-104 (1) (a), Colorado Revised Statutes, is amended to read:

27-10.3-104. Provision of mental health treatment services for youth.

(1) (a) A parent or guardian may apply to a mental health agency on behalf of his or her minor child for mental health treatment services for the child pursuant to this section, whether the child is categorically eligible for medicaid under the capitated mental health system described in section ~~26-4-123~~ 25.5-5-411, C.R.S., or whether the parent believes his or her child is a child at risk of out-of-home placement as defined in section 27-10.3-103 (1). In such circumstances, it shall be the responsibility of the mental health agency to evaluate the child and to clinically assess the child's need for mental health services and, when warranted, to provide treatment services as may be necessary and in the best interests of the child and the child's family. Subject to available state appropriations, the mental health agency shall be responsible for providing the treatment services, including any in-home family mental health treatment, other family preservation services, residential treatment, or any post-residential follow-up services that may be appropriate for the child's or family's needs. A dependency or neglect action pursuant to article 3 of title 19, C.R.S., shall not be required in order to allow a family access to residential mental health treatment services for a child.

SECTION 110. The introductory portion to 27-10.3-105 (1) (a) and 27-10.3-105 (1) (b), Colorado Revised Statutes, are amended to read:

27-10.3-105. Monitoring - report. (1) On or before September 1, 2004, and by September 1 of each year thereafter, each mental health agency shall report to the state department the following information:

(a) The number of children, both those children who are categorically eligible for medicaid under the capitated mental health system described in section ~~26-4-123~~ 25.5-5-411, C.R.S. and those children who are at risk of out-of-home placement as defined in section 27-10.3-103 (1), to whom the following services were provided:

(b) The number of children, both those children who are categorically eligible for medicaid under the capitated mental health system described in section ~~26-4-123~~ 25.5-5-411, C.R.S. and those children who are at risk of out-of-home placement as defined in section 27-10.3-103 (1), referred to the county department for a dependency or neglect investigation pursuant to section 27-10.3-104 (2), and the reasons therefore;

SECTION 111. 27-10.3-106 (1), Colorado Revised Statutes, is amended to read:

27-10.3-106. Funding - rules. (1) In order to make mental health treatment available, it is the intent of the general assembly that mental health treatment provided pursuant to this article to each child described in section 27-10.3-103 (1) who is eligible for medicaid based on the child's placement in a residential child care facility pursuant to section ~~26-4-527~~ 25.5-5-306, C.R.S., and who is determined to be eligible for supplemental security income by the federal social security administration, be provided by mental health agencies.

SECTION 112. 27-10.5-103 (1) (f), Colorado Revised Statutes, is amended to read:

27-10.5-103. Duties of the executive director - rules. (1) In order to implement the provisions of this article, the executive director shall, subject to available appropriations, carry out the following duties:

(f) Consistent with the policies adopted by the department of health care policy and financing, implement the provision of home- and community-based services to eligible persons with developmental disabilities and pursue other medicaid-funded services determined by the department to be appropriate for persons with developmental disabilities, pursuant to ~~subparts 2 and 4 of part 6 of article 4 of title 26~~ PART 4 OF ARTICLE 6 OF TITLE 25.5, C.R.S., and subject to available appropriations; and

SECTION 113. 27-13-110 (2) (a), Colorado Revised Statutes, is amended to read:

27-13-110. Alternative uses for institute facilities - repeal. (2) (a) To the extent that resources at Colorado mental health institute at Pueblo are in excess of the needs of the primary purpose of said institute and the purposes of subsection (1) of this section, the institute is authorized to accept and treat uninsured individuals for medical care or treatment. An uninsured person seeking care or treatment from the institute shall provide sufficient evidence that he or she is without insurance from his or her employer and not enrolled in the state's medical assistance program pursuant to ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S. The department of human services may determine by rule what evidence may be requested. The uninsured person shall be responsible for payment of charges for care and treatment by the institution. The Colorado mental health institute at Pueblo shall charge such uninsured individuals a rate that is comparable to the rate charged for services rendered for enrollees in the state's medical assistance program pursuant to ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S.

SECTION 114. 30-28-115 (2) (b) (II), Colorado Revised Statutes, is amended to read:

30-28-115. Public welfare to be promoted - legislative declaration - construction. (2) (b) (II) The general assembly declares that the establishment of group homes for the aged for the exclusive use of not more than eight persons sixty years of age or older per home is a matter of statewide concern. The general assembly further finds and declares that it is the policy of this state to enable and assist persons sixty years of age or older who do not need nursing facilities and who so elect to live in normal residential surroundings, including single-family residential units. Group homes for the aged shall be distinguished from nursing facilities, as defined in section ~~26-4-103 (11)~~ 25.5-4-103 (14), C.R.S., and institutions providing life care, as defined in section 12-13-101 (5), C.R.S. Every county having adopted or which shall adopt a zoning ordinance shall provide for the location of group homes for the aged. A group home for the aged established under this paragraph (b) shall not be located within seven hundred fifty feet of another such group home, unless otherwise provided for by the county.

SECTION 115. 31-15-201 (1) (g), Colorado Revised Statutes, is amended to read:

31-15-201. Administrative powers. (1) The governing bodies in municipalities shall have the following general powers in relation to the administration of the municipality's affairs:

(g) To provide for the management and operation of any municipally owned hospital by any entity, public or private, profit or nonprofit, which the municipality determines will provide adequate and efficient administration for the operation of such hospital and to enter into contracts relating to such municipally owned hospital as authorized by ~~article 15 of title 26~~ PART 1 OF ARTICLE 3 OF TITLE 25.5, C.R.S.;

SECTION 116. 31-23-303 (2) (b) (II), Colorado Revised Statutes, is amended to read:

31-23-303. Legislative declaration. (2) (b) (II) The general assembly declares that the establishment of group homes for the aged for the exclusive use of not more than eight persons sixty years of age or older per home is a matter of statewide concern. The general assembly further finds and declares that it is the policy of this state to enable and assist persons sixty years of age or older who do not need nursing facilities, and who so elect, to live in normal residential surroundings, including single-family residential units. Group homes for the aged shall be distinguished from nursing facilities, as defined in section ~~26-4-103 (11)~~ 25.5-4-103 (14), C.R.S., and institutions providing life care, as defined in section 12-13-101 (5), C.R.S. Every municipality having adopted or which shall adopt a zoning ordinance shall provide for the location of group homes for the aged. A group home for the aged established under this paragraph (b) shall not be located within seven hundred fifty feet of another such group home, unless otherwise provided for by the municipality. Nothing in this paragraph (b) shall be construed to exempt such group homes from compliance with any state, county, or municipal health, safety, and fire codes. On April 29, 1976, every person sixty years of age or older who resides in a skilled or intermediate health care facility and who may be transferred or discharged therefrom to a group home for the aged shall not be so discharged or transferred unless he or she has received ninety days' advance written notice thereof or has agreed in writing to the proposed transfer or discharge.

SECTION 117. 38-10-111.5, Colorado Revised Statutes, is amended to read:

38-10-111.5. Trusts to establish or maintain eligibility for certain public assistance void - exceptions. Any trust established by or for a person, that consists of the person's individual assets, income, or property of any kind, shall be void for the purpose of establishing or maintaining eligibility for any public assistance as provided by article 2 of title 26, C.R.S., or medical assistance as provided by ~~article 4 of title 26~~ ARTICLES 4, 5, AND 6 OF TITLE 25.5, C.R.S., unless the trust is established in accordance with the provisions of sections 15-14-412.6 to 15-14-412.9, C.R.S.

SECTION 118. 39-26-123 (3), Colorado Revised Statutes, is amended to read:

39-26-123. Receipts - disposition. (3) (a) For fiscal year 2002-03, the allocation

of receipts under sub-subparagraph (A) of subparagraph (I) of paragraph (a) of subsection (2) of this section to the general fund shall be decreased by one million dollars, and such amount shall be credited to the supplemental old age pension health and medical care fund created in section 26-2-117 (3), C.R.S., pursuant to House Bill 02-1276, enacted at the second regular session of the sixty-third general assembly, WHICH SECTION WAS RELOCATED TO SECTION 25.5-2-101, C.R.S., IN 2006. The modifications to the allocation of receipts made pursuant to this subsection (3) shall be in addition to any other modifications to the allocation of such receipts made by law.

(b) Beginning in fiscal year 2003-04, and for each fiscal year thereafter, the allocation of receipts under sub-subparagraph (A) of subparagraph (I) of paragraph (a) of subsection (2) of this section to the general fund shall be decreased by seven hundred fifty thousand dollars, and such amount shall be credited to the supplemental old age pension health and medical care fund created in section 26-2-117 (3), C.R.S., WHICH WAS RELOCATED TO SECTION 25.5-2-101, C.R.S., IN 2006. The modifications to the allocation of receipts made pursuant to this subsection (3) shall be in addition to any other modifications to the allocation of such receipts made by law.

SECTION 119. 42-2-306 (1) (a) (I) and (1) (a) (II), Colorado Revised Statutes, are amended to read:

42-2-306. Fees - disposition - repeal. (1) The department shall charge and collect the following fees:

(a) (I) Except as provided in subparagraph (III) of this paragraph (a), before July 1, 2006, a fee of three dollars and fifty cents at the time of application for an identification card or renewal of an identification card; except that, for applicants sixty years of age or older and applicants referred by any county department of social services pursuant to section 26-2-106 (3), C.R.S., or section ~~26-4-106 (3)~~ 25.5-4-205 (3), C.R.S., there shall be no fee.

(II) Except as provided in subparagraph (III) of this paragraph (a), on and after July 1, 2006, a fee of seven dollars at the time of application for an identification card or renewal of an identification card; except that, for applicants sixty years of age or older and applicants referred by any county department of social services pursuant to section 26-2-106 (3), C.R.S., or section ~~26-4-106 (3)~~ 25.5-4-205 (3), C.R.S., there shall be no fee.

SECTION 120. 24-75-106 (1), Colorado Revised Statutes, is amended to read:

24-75-106. Transfers between departments of health care policy and financing and human services for medicaid programs - repeal. (1) Notwithstanding the effect of the "M" provision in the 1990-91 and subsequent general appropriation acts, the governor may transfer unlimited amounts of general fund AND CASH FUNDS EXEMPT appropriations to and from the departments of health care policy and financing and human services when required by changes from the appropriated levels in the amount of medicaid cash funds earned through programs or services provided under the supervision of the department of human services OR THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING.

SECTION 121. Harmonization of relocated statutes. Pursuant to sections 2-4-301 and 2-5-103, Colorado Revised Statutes, the revisor of statutes shall renumber the statutory sections of any other bill enacted during the second regular session of the sixty-fifth general assembly that amends any provision being relocated by this act and shall harmonize amendments made to said sections with those contained in this act.

SECTION 122. Appropriation - adjustments to 2006 long bill. (1) In addition to any other appropriation, there is hereby appropriated, to the department of health care policy and financing, executive director's office, for county administration, the sum of eighteen million three hundred six thousand six hundred twenty-eight dollars (\$18,306,628), or so much thereof as may be necessary, for the implementation of this act. Of said sum, five million four hundred thirty-five thousand three hundred ninety-six dollars (\$5,435,396) shall be from the general fund and is subject to the "(M)" notation as defined in the general appropriation act, three million seven hundred seventeen thousand nine hundred eighteen dollars (\$3,717,918) shall be cash funds exempt from local funds, and nine million one hundred fifty-three thousand three hundred fourteen dollars (\$9,153,314) shall be from federal funds.

(2) In addition to any other appropriation, there is hereby appropriated, to the department of health care policy and financing, to the executive director's office, for administrative case management payments to counties, the sum of one million five hundred ninety-three thousand six hundred twenty-four dollars (\$1,593,624). Of said sum, seven hundred ninety-six thousand eight hundred twelve dollars (\$796,812) shall be from the general fund and is subject to the "(M)" notation as defined in the general appropriation act, and seven hundred ninety-six thousand eight hundred twelve dollars (\$796,812) shall be from federal funds.

(3) For the implementation of this act, appropriations made in the annual general appropriation act for the fiscal year beginning July 1, 2006, to the department of health care policy and financing shall be adjusted as follows:

(a) The appropriation to the executive director's office, for personal services, is increased by fifty-five thousand dollars (\$55,000) and 1.0 FTE. Of said sum, twenty-seven thousand five hundred dollars (\$27,500) shall be from the general fund and is subject to the "(M)" notation as defined in the general appropriation act, and twenty-seven thousand five hundred dollars (\$27,500) shall be from federal funds.

(b) The appropriation to the executive director's office, for operating expenses, is increased by one thousand dollars (\$1,000). Of said sum, five hundred dollars (\$500) shall be from the general fund and is subject to the "(M)" notation as defined in the general appropriation act, and five hundred dollars (\$500) shall be from federal funds.

(c) The appropriation to the other medical services division, for home care allowance, is decreased by ten million eight hundred eighty thousand four hundred eleven dollars (\$10,880,411). Of said sum, ten million three hundred thirty-six thousand three hundred ninety dollars (\$10,336,390) shall be from the general fund, and five hundred forty-four thousand twenty-one dollars (\$544,021) shall be cash

funds exempt from local funds.

(d) The appropriation to the other medical services division, for adult foster care, is decreased by one hundred fifty-seven thousand four hundred sixty-nine dollars (\$157,469). Of said sum, one hundred forty-nine thousand five hundred ninety-six dollars (\$149,596) shall be from the general fund, and seven thousand eight hundred seventy-three dollars (\$7,873) shall be cash funds exempt from local funds.

(e) The appropriation to the department of human services - medicaid-funded programs division, for the office of operations - medicaid funding, is decreased by twenty-six thousand nine hundred seventy-six dollars (\$26,976). Of said sum, thirteen thousand four hundred eighty-eight dollars (\$13,488) shall be from the general fund and is subject to the "(M)" notation as defined in the general appropriation act, and thirteen thousand four hundred eighty-eight dollars (\$13,488) shall be from federal funds.

(f) The appropriation to the department of human services - medicaid-funded programs division, for county administration - medicaid funding, is decreased by fourteen million five hundred eighty-eight thousand seven hundred ten dollars (\$14,588,710). Of said sum, five million four hundred thirty-five thousand three hundred ninety-six dollars (\$5,435,396) shall be from the general fund and is subject to the "(M)" notation as defined in the general appropriation act, and nine million one hundred fifty-three thousand three hundred fourteen dollars (\$9,153,314) shall be from federal funds.

(g) The appropriation to the department of human services - medicaid-funded programs division, for the division of child welfare - medicaid funding, for child welfare services, is decreased by five hundred eighty-eight thousand nine hundred forty-four dollars (\$588,944). Of said sum, two hundred ninety-four thousand four hundred seventy-two dollars (\$294,472) shall be from the general fund and is subject to the "(M)" notation as defined in the general appropriation act, and two hundred ninety-four thousand four hundred seventy-two dollars (\$294,472) shall be from federal funds.

(h) The appropriation to the department of human services - medicaid-funded programs division, division of child welfare - medicaid funding, for family and children's programs, is decreased by one million four thousand six hundred eighty dollars (\$1,004,680). Of said sum, five hundred two thousand three hundred forty dollars (\$502,340) shall be from the general fund and is subject to the "(M)" notation as defined in the general appropriation act, and five hundred two thousand three hundred forty dollars (\$502,340) shall be from federal funds.

(i) The appropriation to the department of human services medicaid-funded programs division, services for people with developmental disabilities - medicaid funding, for regional centers, is decreased by twenty-nine thousand twenty-four dollars (\$29,024). Of said sum, fourteen thousand five hundred twelve dollars (\$14,512) shall be from the general fund and is subject to the "(M)" notation as defined in the general appropriation act, and fourteen thousand five hundred twelve dollars (\$14,512) shall be from federal funds.

(4) For the implementation of this act, appropriations made in the annual general

appropriation act for the fiscal year beginning July 1, 2006, to the department of human services shall be adjusted as follows:

(a) The general fund appropriation to the executive director's office, special purpose, for the office of performance improvement, is decreased by twenty-nine thousand twenty-three dollars (\$29,023).

(b) The appropriation to the office of operations, administration, for personal services, is decreased by fifty-six thousand dollars (\$56,000) and 1.0 FTE. Of said sum, twenty-nine thousand twenty-four dollars (\$29,024) shall be from the general fund and is subject to the "(M)" notation as defined in the general appropriation act, and twenty-six thousand nine hundred seventy-six dollars (\$26,976) shall be cash funds exempt from the transfer of medicaid funding from the department of health care policy and financing.

(c) The cash funds exempt appropriation to the county administration division, for county administration, is decreased by eighteen million three hundred six thousand six hundred twenty-eight dollars (\$18,306,628). Said sum shall be from medicaid funds transferred from the department of health care policy and financing.

(d) The cash funds exempt appropriation to the division of child welfare, for child welfare services, is decreased by five hundred eighty-eight thousand nine hundred forty-four dollars (\$588,944). Said sum shall be from medicaid funds transferred from the department of health care policy and financing.

(e) The cash funds exempt appropriation to the division of child welfare, for family and children's programs, is decreased by one million four thousand six hundred eighty dollars (\$1,004,680). Said sum shall be from medicaid funds transferred from the department of health care policy and financing.

(f) The cash funds exempt appropriation to the services for people with disabilities division, developmental disability services, regional centers, for personal services, is decreased by twenty-nine thousand twenty-four dollars (\$29,024). Said sum shall be from medicaid funds transferred from the department of health care policy and financing.

(g) The general fund appropriation to the adult assistance programs division, for administration, is increased by fifty-eight thousand forty-seven dollars (\$58,047) and 1.0 FTE.

(h) The general fund appropriation to the adult assistance programs division, other grant programs, for home care allowance, is increased by ten million three hundred thirty-six thousand three hundred ninety dollars (\$10,336,390).

(i) The cash funds exempt appropriation to the adult assistance programs division, other grant programs, for home care allowance, is increased by five hundred forty-four thousand twenty-one dollars (\$544,021). Said sum shall be from local funds.

(j) The cash funds exempt appropriation to the adult assistance programs division, other grant programs, for home care allowance, is decreased by ten million

eight hundred eighty thousand four hundred eleven dollars (\$10,880,411). Said sum shall be from funds transferred from the department of health care policy and financing.

(k) The general fund appropriation to the adult assistance programs division, other grant programs, for adult foster care, is increased by one hundred forty-nine thousand five hundred ninety-six dollars (\$149,596).

(l) The cash funds exempt appropriation to the adult assistance programs division, other grant programs, for adult foster care, is increased by seven thousand eight hundred seventy-three dollars (\$7,873). Said sum shall be from local funds.

(m) The cash funds exempt appropriation to the adult assistance programs division, other grant programs, for adult foster care, is decreased by one hundred fifty-seven thousand four hundred sixty-nine dollars (\$157,469). Said sum shall be from funds transferred from the department of health care policy and financing.

SECTION 123. Effective date. This act shall take effect July 1, 2006.

SECTION 124. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Approved: June 6, 2006